

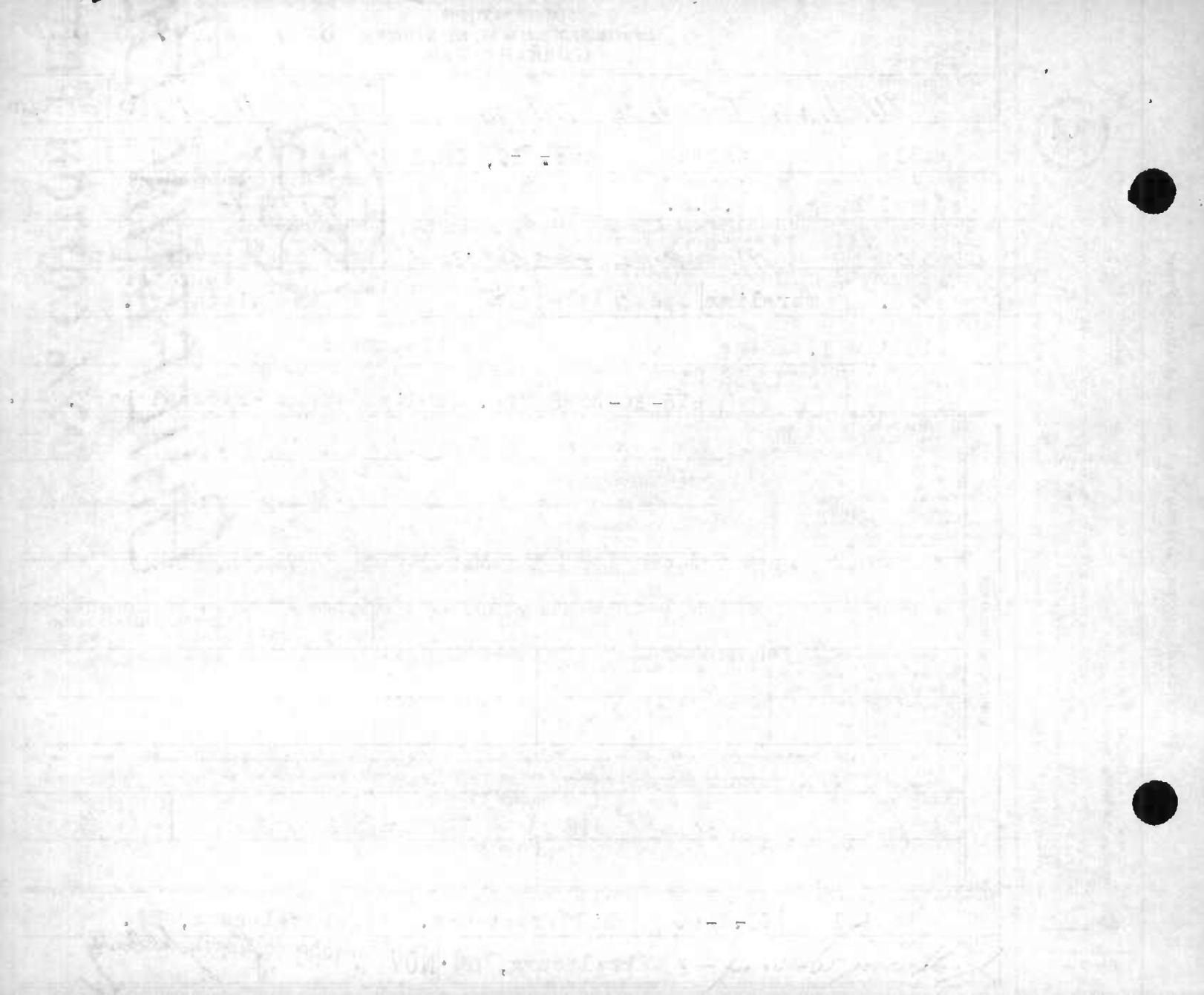
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8029687			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
<i>William Theodore Adams</i>							<i>11/1/80</i>				11	<i>0155AM</i>	
3. SEX			4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>male</i>			<i>white</i>		<i>Aug. 19, 1891</i>		89		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		9b. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Federalsburg</i>			<i>U.S.A.</i>				<i>Talbot</i>		<i>MD.</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
<i>EASTON</i>			<i>Memorial Hospital</i>							<i>retired service station operator</i>			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS				
<i>Md.</i>			<i>Caroline</i>		<i>Federalsburg</i>				<i>Buena Vista Ave.</i>				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
<i>William T. Adams</i>			<i>Ida Fleetwood</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
<i>No</i>			<i>215-26-5293</i>		<i>Mrs. Pauline Adams - Federalsburg, Md.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured abdominal aortic aneurysm</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cessation of circulatory and vascular disease</i>													
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/31</i> , 19 <i>80</i> , to <i>11/1</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11/1</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>11/1/80</i>	
22b. SIGNATURE <i>John B. Bissell</i>			DEGREE <i>MD</i>							ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY			23f. STATE	
<i>burial</i>			<i>11-3-80</i>		<i>Hillcrest Cem.</i>		<i>Federalsburg, Md.</i>						
24. FUNERAL DIRECTOR <i>James Williams - Federalsburg, Md.</i>			25a. DATE REC'D. BY REGISTRAR							25b. REGISTRATION NUMBER			
			<i>NOV 7 1980</i>							<i>11-11-80</i>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 29688	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Jessie M.	MIDDLE	LAST Barnes	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
3. SEX			4 RACE	5. DATE OF BIRTH MONTH 7 DAY 27 YEAR 84		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		11 35 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTHS 96 YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
8. CITY OR TOWN OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Queen Anne's			13c. CITY OR TOWN Chester			13d. STREET ADDRESS RT #1 Box 553		
14. FATHER'S NAME FIRST Caleb			MIDDLE	LAST Rosa	15. MOTHER'S MAIDEN NAME Estella			MIDDLE	LAST Scott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 503-12-2350			17. INFORMANT Lucille Rosa Heilman, Box 1440 Ocean Pines, Be			ADDRESS Berlin, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senile dementia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (this hospital) attended the deceased from 7/21/1976 to Nov 28, 1980, that (I) (we) last saw the deceased alive on Nov 28, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael A. Moskowicz										DEGREE	22c. DATE SIGNED 11/28/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 503 Bryn St Cambridge Md 21613			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11-29-80			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory			23d. LOCATION CITY OR TOWN Suitland, MD STATE County P.G. Co. Md.		
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home			24b. ADDRESS Helfenbein-Hubbard Chester Md. Chester Md.			24c. DATE REC'D. FOR TRANSMISSION 11/28/80			24d. SIGNATURE		

10

the 20th August

Dear Sirs

As you will

see from my letter
of the 10th instant I
have the pleasure to inform you

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29689							
										REG. NO.							
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			Theodore			Boulden			Nov 10 80			55 ³³ 5 AM					
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS				
Male		Negro		1 25 86			99			YRS			MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Md		USA					Talbot										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
EASTON		Memorial Hospital		Laborer													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Md		Calvert		EASTON			Route # 2 Box 291										
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Edward		Morrice Carter															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO			17 INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
NO		258-30-0922			Brida Harris												
II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stroke</u>																	
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF <u>atherosclerotic Vase Disease</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Coronary artery disease ; Seizures</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>10-28</u> , 19 <u>80</u> , to <u>11-10</u> , 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>11-9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Terry P. Petrich</u>		22c. DEGREE <u>Nurs.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>11-10-80</u>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SUGGEST)		23b. DATE <u>11-10-80</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Memorial Cemetery</u>			23d. LOCATION CITY OR TOWN <u>EASTON</u>			COUNTY		STATE					
24 FUNERAL DIRECTOR <u>Henry H. Hall Jr.</u>		ADDRESS <u>101 W. Preston St.</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 20 1980</u>			25b. REGISTRAR'S SIGNATURE <u>R. J. Murphy</u>									

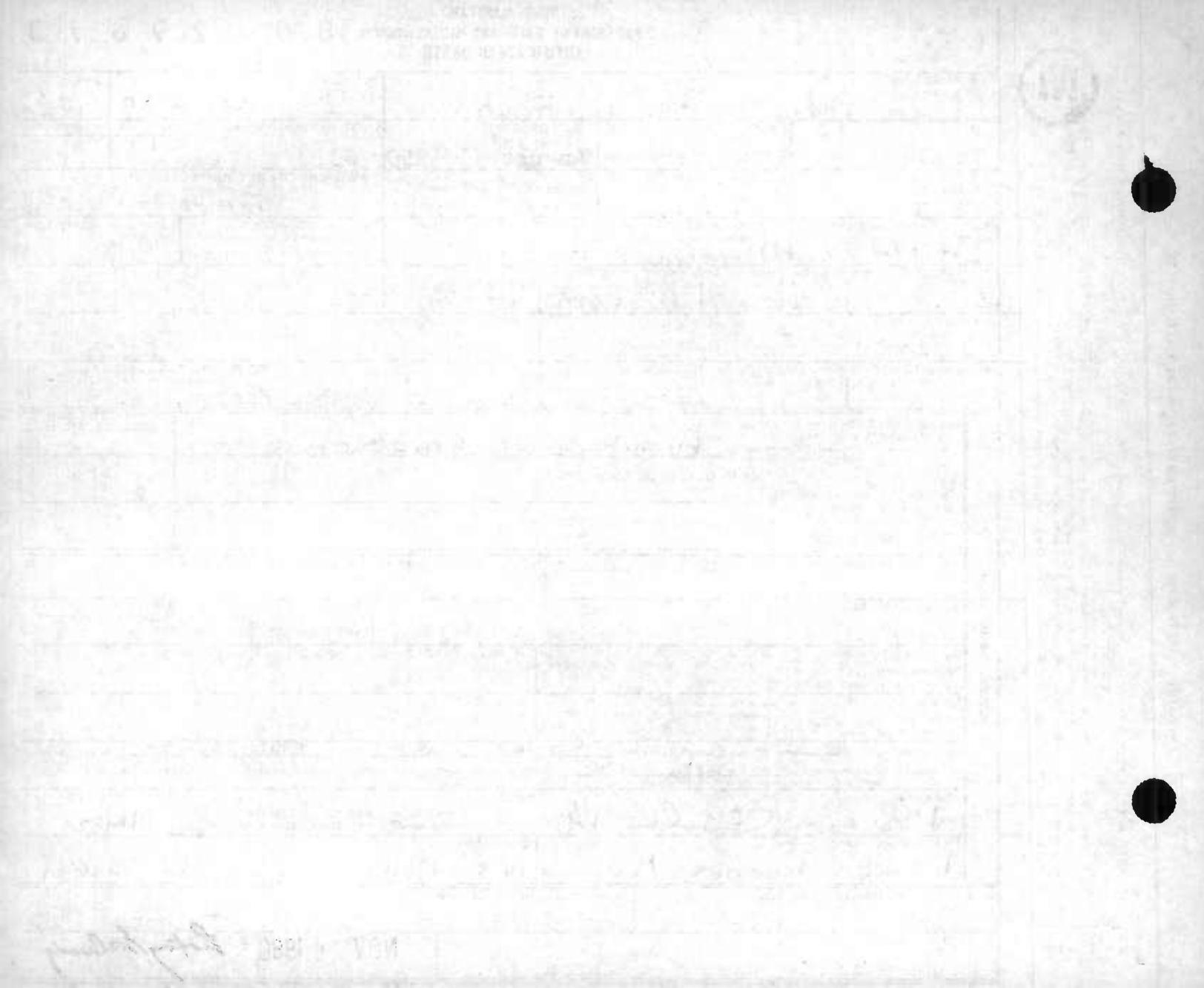
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29690	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Doris			H.R.	Brittingham		Nov 2 1980					12:45 PM		
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS.			
Female			Caucasian	August 11 1930			50			MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			U.S.A.						Talbot				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton			Memorial Hospital			Branch Manager			Bank				
13a. STATE Del.			13c. CITY OR TOWN Sussex		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 124 Irons Ave.					
14. FATHER'S NAME Reginald			MIDDLE H.	LAST Higgins	15. MOTHER'S MAIDEN NAME Dorothy			16. ADDRESS 410 Salmons Ave.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 213-24-0433			17. INFORMANT Lewis Brittingham			Lewis Brittingham Easton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma —												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (his hospital) attended the deceased from Spring 1980, to Oct 2 1980, that (II) (we) last saw the deceased alive on Sept 19 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, (I) (we) did not view the body after death.)													
22b. SIGNATURE P. Rhodes MD.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED 11/2/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Rhodes MD.			22e. ADDRESS 140. Aurora, Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-4-80			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cem.			23d. LOCATION CITY OR TOWN Easton COUNTY Talbot Md.				
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			25a. DATE RECEIVED BY REGISTRAR NOV 6 1980						25b. RELEASER SIGNATURE R. Newnam				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILLER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30 29691					
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH DAY YEAR	2b. HOUR
		<i>George</i>			o.						<i>Brown</i>			<input type="checkbox"/> 11 30 1980		11 14 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		9. DATE PRONOUNCED DEAD		10. DATE MONTH DAY YEAR		2d. HOUR	
Male		White		Nov. 7 1916		64 yrs.						11 - 30 1980		11 14 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Ohio		U.S.A.												<i>Talbot</i>		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
<i>Easton</i>		<i>Memorial</i>		Farmer													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Md.		Talbot		Trappe		R.D. #1, Box 247											
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Charley		Roscoe		Brown		Bertha		Alice		Allen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		286-18-9651		<i>Mary L. Brown</i>		see item #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4149</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Chronic Perla, Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. { DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).																	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>R. Lane Wroth</i>														TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth M. D.														DATE SIGNED 12-1-80			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		12-4-80		Evergreen Mem. Garden Finksburg		Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Newnam Funeral Home		Easton, Md.		DEC 4 1980		<i>John McElroy</i>											



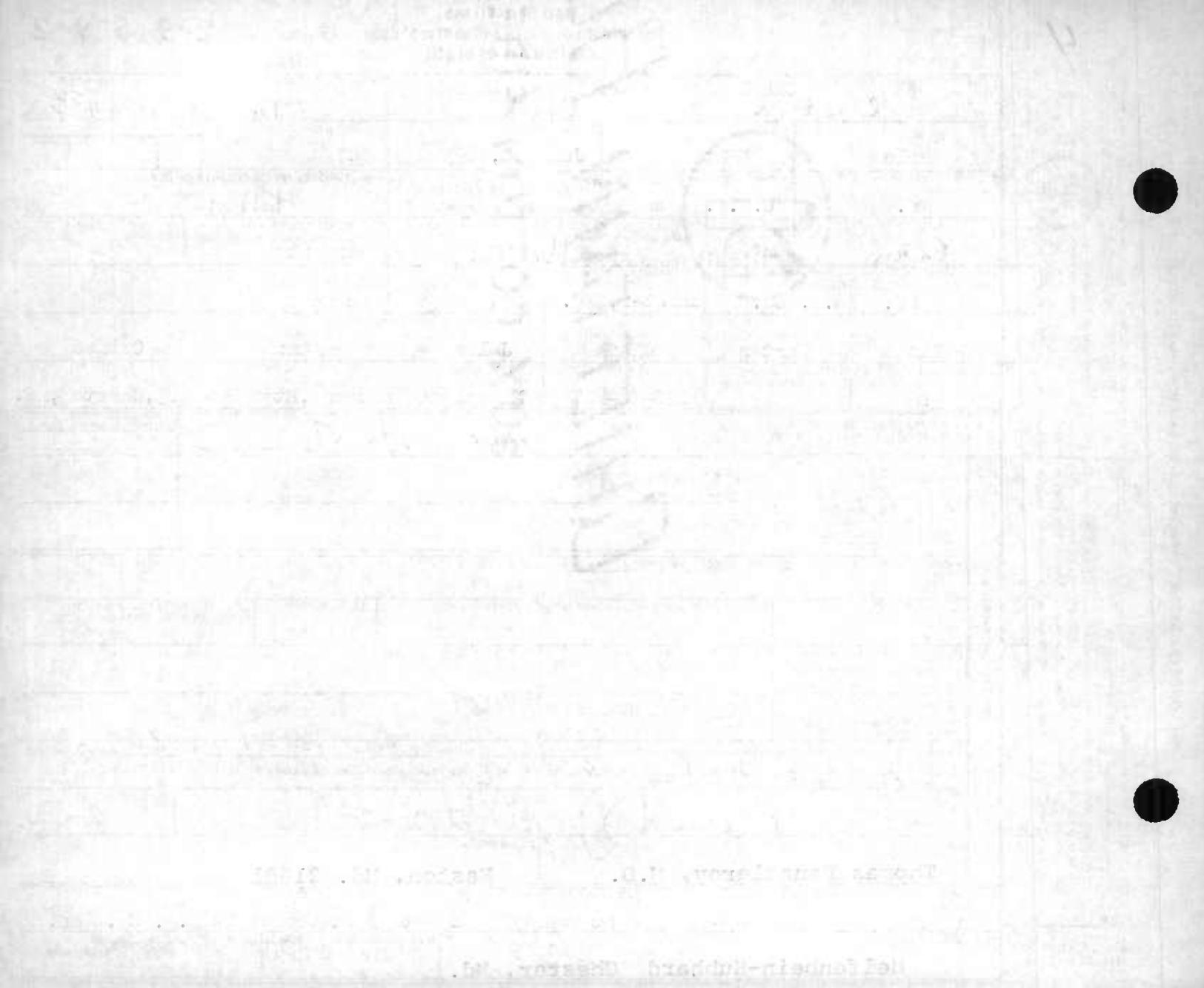
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80 29692
					REG. NO.
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			LAST	2a. DATE OF DEATH MONTH DAY YEAR
	FIRST	MIDDLE	Clayland Walter Clark	Clark	Nov. 1, 1980
	Clayland				455 P M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male	White	June 20, 1899			81 YRS.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.
Md.	U.S.A. m				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter	
Easton	the Memorial Hospital			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS none	
Md.	Q.A. Co.	Chester, Md.			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	
William	Barton		Clark	Julia	MIDDLE LAST Anna Grimes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT Magdalene Walters, Rt#1 Box #85, Chester, Md.			ADDRESS
no	220-26-8279				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4375 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11-1-80 to 11-1-80, that (we) lost saw the deceased alive on 11-1-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (if we did not view the body after death.)					
22b. SIGNATURE <i>Thomas Fauntleroy, M.D.</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-2-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS Thomas Fauntleroy, M.D. Easton, Md. 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-5-80	23c. NAME OF CEMETERY OR CREMATORIUM Stevensville Cemetery	23d. LOCATION CITY OR TOWN Stevensville	COUNTY Q.A. Co.	STATE Md.
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard	ADDRESS 21619 Chester, Md.	25a. DATE REC'D. BY REGISTRAR NOV 10 1980	25b. REC'D. BY TRANS. SIGNATURE <i>Henry McHenry</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80	29693				
					REG. NO.					
1 - STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT)	VIOLA	R.	COLLINS	11	29	80	10:10M			
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	
Female	White	MONTH	DAY	YEAR	87	YRS.				
June 1, 1893										
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U. S. A.				TALBOT					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
EASTON	HOUSE IN THE PINES					School Teacher				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland	Caroline	Federalsburg	YES <input type="checkbox"/>	NO <input type="checkbox"/>		University Ave.				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
Isaac	Wesley	Lowe	Collins	FIRST			Elizabeth	MIDDLE	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
n/a	193-20-7616	William Kent			Newark, Delaware					
18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c.) PART I. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) ASCVD										
4392 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Recent		CVA		Oct 1980		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
P.M.		19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8 19 78 to 11 19 80, that (we) lost saw the deceased alive on 11/14 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.										
22b. SIGNATURE		MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		Dec. 2, 1980		Hillcrest		Federalsburg		Car.	Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Edna Williamson Federalsburg, Md.				DEC 4 1980		R. J. Tracy				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80 29694
					REG. NO.
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
		11-17-80			10:50 PM
31. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	
<i>James Dawson Coursey</i>					
32. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		Caucasian		Dec. 28, 1898	
7a. PLACE OF DEATH (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U. S. A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Easton, Maryland		<i>Easton Memorial</i>		Farmer	
13a. STATE Maryland		13c. CITY OR TOWN Caroline		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		Ridgely		13e. STREET ADDRESS Holly Road	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	
James		L.	Coursey	Sarah	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No		215362261		Ethel Coursey, Ridgely, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart failure</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>none</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-26-</u> 19 <u>80</u> , to <u>11-17</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11-17</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Robert W. Trever, M.D.</i>		DEGREE		22c. DATE SIGNED <u>11-18-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert W. Trever, M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <i>RD 3 Easton, Md. 21601</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <u>11/20/80</u>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Denton Cemetery</i>	
23d. LOCATION CITY OR TOWN <i>Denton</i>		23e. COUNTY <i>Caroline</i>		23f. STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Moore Funeral Home Denton, Md.</i>		25. DATE REC'D. BY REGISTRAR <u>NOV 20 1980</u>		26. REGISTRAR'S SIGNATURE <i>Henry Belong</i>	
DHMH-16 30M 2/80 (VRA 15, 4)					

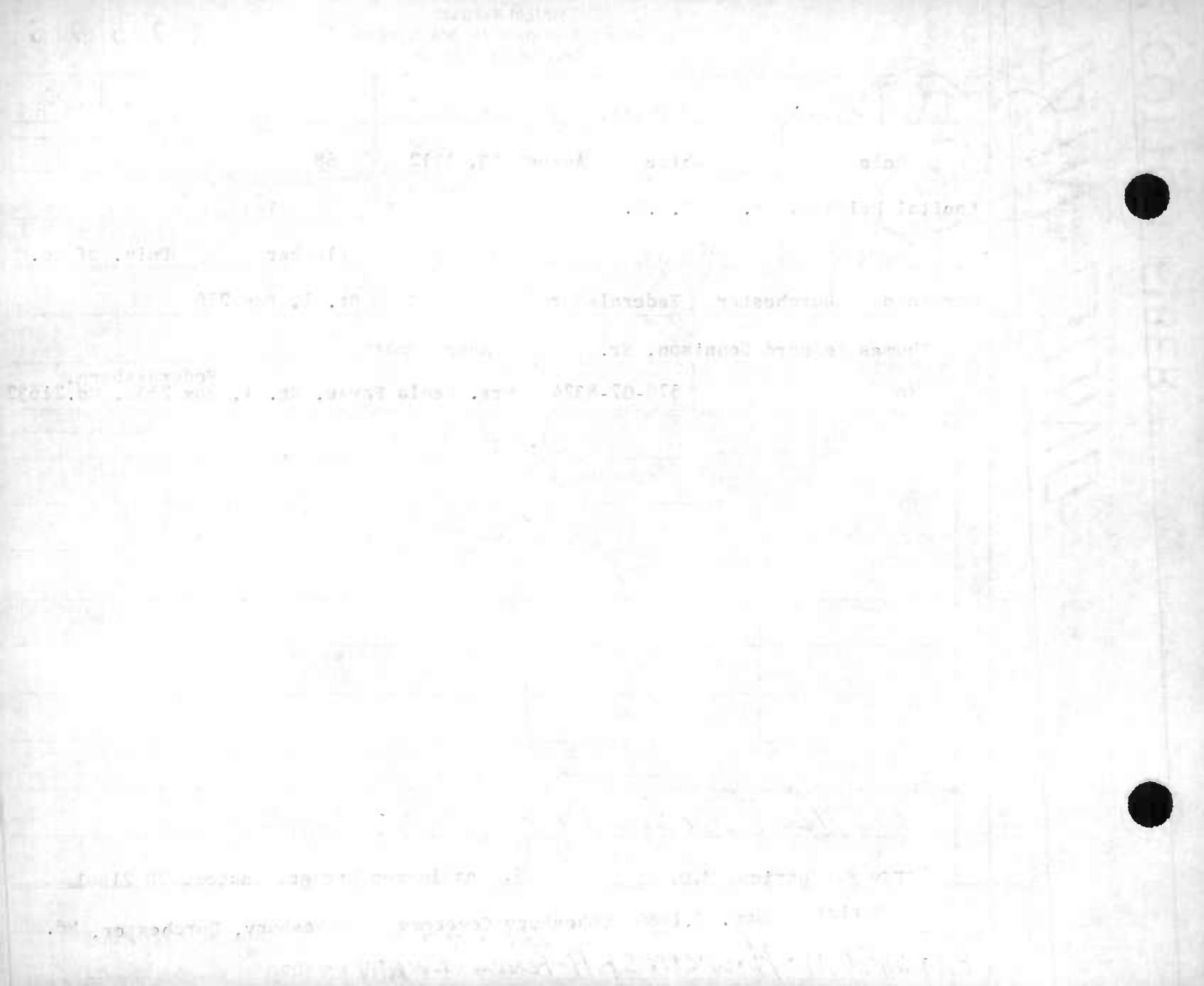
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8029695			
										REG. NO.			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR			
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			Nov. 6, 1980 9 ¹⁰ M			
2c Thomas			Leonard		Dennison, Jr.								
3 SEX Male			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR August 13, 1912			6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Capital Heights, Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot		MD.		
10 CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Memorial Hospital							12a USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Plumber		12b KIND OF BUSINESS OR INDUSTRY Univ. of Md.	
13a STATE Maryland			13b COUNTY Dorchester		13c CITY OR TOWN Federalsburg			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 1, Box 256			
14 FATHER'S NAME FIRST Thomas			MIDDLE Leonard			LAST Dennison, Sr.			15 MOTHER'S MAIDEN NAME FIRST Anna		MIDDLE LAST		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-07-8324			17 INFORMANT Mrs. Leola Payne, Rt. 1, Box 255D, Md. 21632			ADDRESS Federalsburg, Md. 21632		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360										<i>CVA</i>			
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension - Ischaemic Disease													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 11-6, 1980 , to 11-6, 1980 , that (we) lost the deceased alive on 11-6, 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.										22c DATE SIGNED			
22b SIGNATURE M. Detrich			22d DEGREE M.D.							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Terry P. Detrich, M.D.			22e ADDRESS S. Washington Street, Easton, MD 21601										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Nov. 9, 1980			23c NAME OF CEMETERY OR CREMATORIAL Cokesbury Cemetery			23d LOCATION CITY OR TOWN Cokesbury - Dorchester		COUNTY STATE Md.		
24 FUNERAL DIRECTOR NAME FRAMPTON - HAWKINS F.H. - FEDERALSBURG			25a DATE REC'D. BY REGISTRAR NOV 13 1980							25b REGISTRAR'S SIGNATURE R. Detrich			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, resented by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/funeral permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	29696				
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			GOOTIE WILLIAM			EMORY			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
SEX MALE			RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR SEPT 25, 1898			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	MD. HRS.	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			10. CITY OR TOWN OF DEATH EASTON			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial Hospital				12a. USUAL OCCUPATION LABORER				12b. KIND OF BUSINESS OR INDUSTRY ELECTRIC CO				13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. COUNTY CAROLINE CITY OR TOWN DENTON			
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 514 LINCOLN STREET DENTON, MD (21629)				14. FATHER'S NAME JOHN (NMN) EMORY				15. MOTHER'S MAIDEN NAME HENRIETTA HARRIS EMORY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES WW I				16b. SOCIAL SECURITY NO. 154-07-6252A				17. INFORMANT RECORDS OF MEMORIAL HOSPITAL				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>renal failure (acute + chronic)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4149</u> <u>b</u> <u>c</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 months years.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>All pneumonia - hx coronary artery disease</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> to <u>4/23</u> , 19 <u>80</u> , to whom (we) last saw the deceased alive on <u>4/23</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <u>Albert T. Dawkins Jr.</u>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/23/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT T. DAWKINS JR, MD			22e. ADDRESS EASTON, MD 21601												
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 12-1-1980			23c. NAME OF CEMETERY OR CREMATORIAL VETERANS CEMT.			23d. LOCATION CITY OR TOWN HURLOCK CAROLINE MD						
24. FUNERAL DIRECTOR NAME Ollie Lee Denton			ADDRESS			25a. DATE REC'D. DEC 3 1980			25b. DATE ENTERED 11/23/80						

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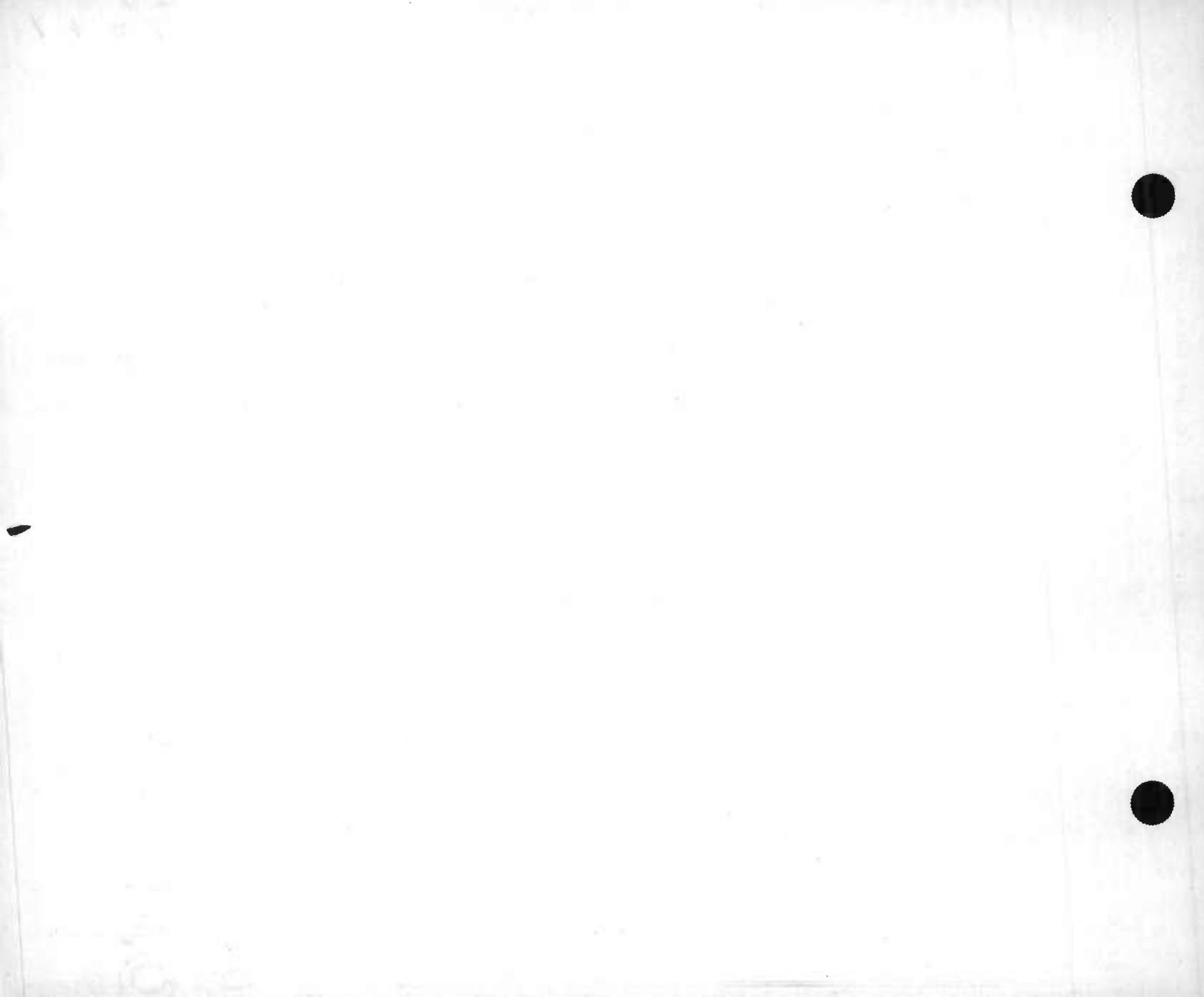
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29697				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Flossie			M	Fitzgerald		11-8-80						6 ¹⁰ A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
F		W		MONTH 19	DAY 1	YEAR 93	84			MONTHS YRS.	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Delaware		U.S.A.					Talbot							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton		House in the Pines			Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Del.		Sussex		Milford		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		306 Rehoboth Avenue						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST					
William		Burt		Macklin	Anna		Ellen		Short					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		R.D. #4, Box 76 BB ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		222-05-6425		Dorothy Green Milford, Del.										
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)														
4370 Conditions, if any, which gave rise to immediate cause 10a, stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/28 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 11/8/80				
22b. SIGNATURE W M H Wood MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) W M H Wood		22d. ADDRESS EASTON, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11-11-80		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Cemetery		23d. LOCATION CITY OR TOWN Lincoln		COUNTY		STATE				
Burial														
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR NOV 13 1980		25b. REGISTRAR'S SIGNATURE Loriann McCloskey								
BP _____														
DHMH-16 20M (VRA 15, 4) 7/78														



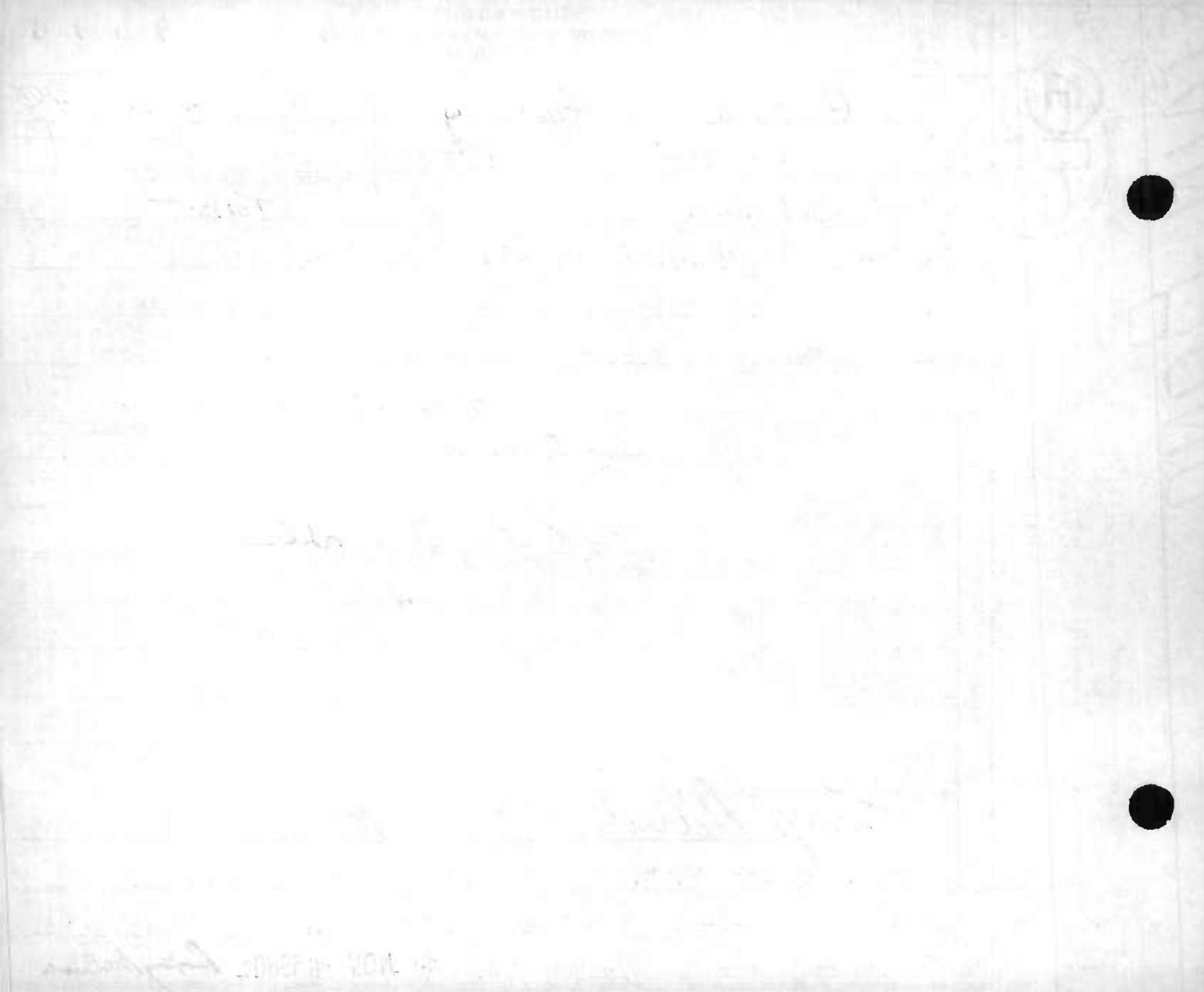
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	29698				
										REG. NO.					
1 - FOR STATE REGISTRAR	I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
	<i>Gertrude</i>					<i>Fluharty</i>	<i>11-3-80</i>				<i>408 P.M.</i>				
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 1 HRS HOURS MIN.				
Female	Caucasian	Nov. 11 1913			66 YRS.										
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH					
Maryland	U.S.A.						<i>Talbot</i>			<i>Easton</i>					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
<i>Memorial Hospital</i>										<i>Housewife</i>			MD.		
13a STATE	13b COUNTY	13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS							
Md.	Talbot	<i>Tilghman</i>						<i>GibsonTown Road</i>							
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS					
James	Wesley		Porter	Gertrude			A.	Dobson							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.			17 INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No	<i>220-28-2000</i>			<i>Charles A. Fluharty see item #13</i>											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Septicemia</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>2849</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>cytotoxic Cerebral</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <i>1979</i> , 19, to <i>Nov. 3, 1980</i> , that (I/we) last saw the deceased alive on <i>11-3-80</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.															
22b. SIGNATURE <i>Terry P. Detrich, M.D.</i>	22c. DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Terry P. Detrich, M.D.</i>	22e. ADDRESS <i>Washington St. Easton, Md.</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE <i>11-6-80</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Mem. Park</i>			23d. LOCATION CITY OR TOWN <i>Easton</i>			COUNTY <i>Talbot</i>			STATE <i>Md.</i>				
24 FUNERAL DIRECTOR NAME Newnam Funeral Home	ADDRESS <i>Easton, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 6 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Hector McCreary</i>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8029699				
										REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2b. HOUR					
Wilson			W.				Fluharty		4:25 P.M.					
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male			Caucasian		Apr. 17 1898		82 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			U.S.A.					Talbot						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Easton			Memorial Hospital							operator			boatyard	
13a. STATE Md.			13b. COUNTY Talbot		13c. CITY OR TOWN Tilghman		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Chicken Point Road					
14. FATHER'S NAME Charles			MIDDLE Edward		LAST Fluharty		15. MOTHER'S MAIDEN NAME Margaret			MIDDLE Elizabeth			LAST Schutz	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 220-12-5112							17. INFORMANT Nora O. Fluharty see item #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Brain stem stroke										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED <small>AT HOME</small> <input type="checkbox"/> NOT WHILE <input type="checkbox"/> <small>AT WORK</small> <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (he/she) attended the deceased from July 19 66, to 18 Nov 19 80, that (I) (we) last saw the deceased alive on 18 Nov 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not have time to view the body after death.										22b. DATE SIGNED 11-18-80				
22c. SIGNATURE Stephen P. Carney			DEGREE M.D.							ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.			22e. ADDRESS Easton, Md.											
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 11-21-80		23c. NAME OF CEMETERY OR CREMATORIAL Landing Neck Cem			23d. LOCATION CITY OR TOWN Trappe		COUNTY Talbot		STATE Md.		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			25a. DATE RECEIVED BY REGISTRY NOV 25 1980							25b. REASON FOR DELAY Pending signature				



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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80 29700	
					REG. NO.	
1 - STATE REGISTRAR	1 DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM	MIDDLE GIBSON	2a. DATE OF DEATH MONTH DAY YEAR Nov. 3 1980	
	3 SEX MALE		4 RACE Negro	5. DATE OF BIRTH MONTH 9 DAY 25 YEAR 98	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 82 YRS DAYS HOURS MIN	
	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA	8 BALTIMORE CITY OR COUNTY OF DEATH TALBOT		
	9 CITY OR TOWN OF DEATH EASTON		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOUSE IN THE PINES	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		
	13a. STATE MD		13b. COUNTY TALBOT	13c. CITY OR TOWN EASTON		
	14 FATHER'S NAME FIRST MIDDLE LAST J.W.		15 MOTHER'S MAIDEN NAME Emma		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 221-07-9485	17 INFORMANT Marcelline	13e. STREET ADDRESS Route #5 Bay 808	
	18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 3/4 yrs			
	1541 Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last. (b)		DUE TO, OR AS A CONSEQUENCE OF (c)			
	PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:					
	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	22a. I certify that (I) (this hospital) attended the deceased from 10-7 19-75 to 11-3 19-80, that (I) (we) last saw the deceased alive on 10-15 19-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
	22b. SIGNATURE		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-3-80	
	22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
	23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11/7/80	23c. NAME OF CEMETERY OR CREMATORIAL Royal Oak	23d. LOCATION CITY/TOWN Royal Oak	23e. COUNTY Anne Arundel
	24. FUNERAL DIRECTOR NAME		ADDRESS	25a. DATE REC'D. BY REGISTRAR NOV 20 1980		25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29701			
										REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Ruth A. Glazier						November 2 1980			12:04 pm	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female		Caucasian		May 5 1909			71 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.					Talbot County						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton		House in the Pines					Housewife						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Md.		Talbot		Easton					201 Federal St.				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			ADDRESS						
Louis				Anna			Shore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		213-76-5706		Nancy G. Fox			days						
18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b1, and 1c.) PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		Pneumonia			years						
4379													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		{		DUE TO, OR AS A CONSEQUENCE OF (b)			Cerebyrosal disease						
		{		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 to 11-2-80, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			DATE SIGNED					
Thomas W. Fauntleroy, Jr. M.D.								11-2-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Burial		11-5-80			Arlington Nat. Cem.			Arlington					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR					
Newnam Funeral Home								25b. REGISTRAR'S SIGNATURE					
								Nov 6 1980					

20.2 miles

13.2

1000' E

1000' contour

1000' contour

1000'

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Failing to do so may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene or your local coroner or embalmer.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 / 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Harry ALVIN					Gordon	11-24	-80			4 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Caucasian	Sept. 13, 1896				84	YRS		MONTHS	DAYS	IF UNDER 24 HRS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania		U. S. A.							Talbot MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital			Farmer			Farm			
13a. USUAL RESIDENCE (IF NURSING HOME OR HER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
Maryland		13c. COUNTY	Caroline		13e. CITY OR TOWN	13e. STREET ADDRESS					
Denton					Denton	406 Fountain Avenue					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		
Levi					Gordon	Rebecca			Statler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			220347502			Ida Mae Gordon, Denton, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for 18 (b), and (c).) PART 1. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>						1 hr					
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS CONSEQUENCE OF (b) <i>Recent Myocardial infarction</i>					
{ DUE TO, OR AS CONSEQUENCE OF (c) <i>Asthma</i>						2 week years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Congestive Heart Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> , 19 <u>80</u> , to <u>11/24</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11/24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Wm. H. Wood Jr.</i>		DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/24/80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm. H. Wood Jr.</i>			22e. ADDRESS <i>EASTON, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Burial</u> <u>11/26/80</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Denton Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Denton</u>		COUNTY <u>Caroline</u>			STATE <u>Md.</u>
24. FUNERAL DIRECTOR NAME <i>RANDOLPH P. MOORE</i>		ADDRESS <i>DEPT. OF MEDICAL RECORDS</i>		PHONE NUMBER <u>301-281-1500</u>		TRANSPORTATION RESERVATION SHEET					

2003102

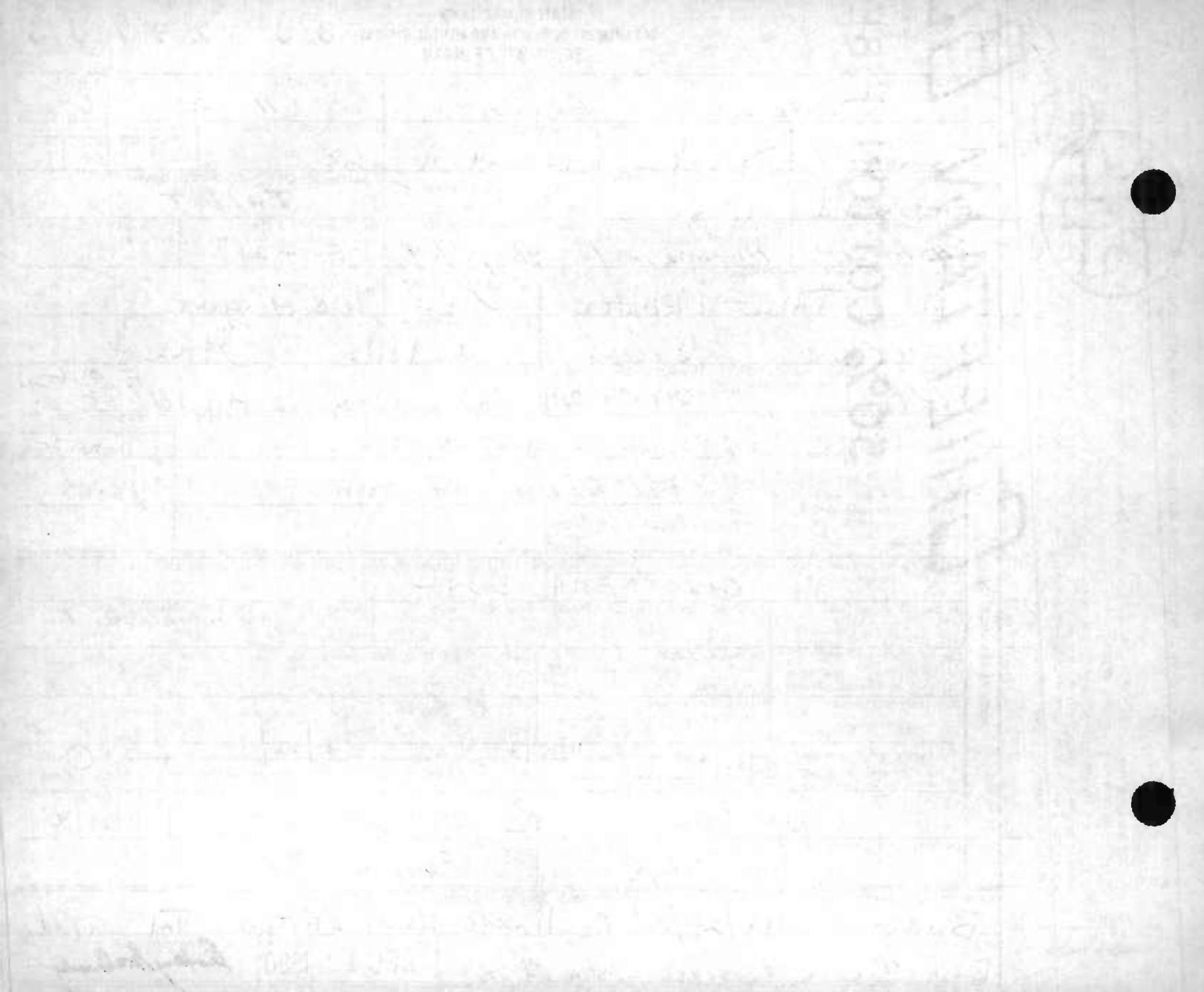
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29103							
												REG. NO.							
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH			DAY	YEAR	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS							
<i>Jadonia</i>					<i>Green</i>	12			24	11	68	6 20							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
<i>Female</i>			<i>Black</i>			MONTH DAY YEAR			YRS.			<i>EASTON MD.</i>		<i>U.S.</i>			<i>Talbot</i>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>EASTON</i>			<i>Memorial Hospital</i>									<i>Fruteray</i>							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
<i>Md.</i>			<i>Talbot</i>			<i>EASTON</i>						<i>108 Higgins</i>							
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST									MIDDLE	LAST				
<i>Ellieck</i>				<i>Green</i>	<i>Adelelyn</i>										<i>Green</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT			ADDRESS				
<i>No</i>			<i>219-34-3291</i>									<i>Sadien Wing</i>			<i>EASTON</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY METASTASES.</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 MONTH</i>				
1541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARCINOMA RECTUM</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARCINOMA LUNG</i> DUE TO, OR AS A CONSEQUENCE OF																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>11/16/80</i> , 19 <i>80</i> , to <i>11/22/80</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11/21/80</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.																			
22b. SIGNATURE <i>C.W. Barn</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>11/22/80</i>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C.W. Barn</i>			22e. ADDRESS <i>Boston, Md.</i>																
23a. BURIAL, CREMATION, REMOVAL (IF)			23b. DATE <i>11/29/80</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Richards Mem</i>			23d. LOCATION CITY OR TOWN <i>EASTON Tal</i>			STATE <i>Md.</i>							
24. FUNERAL DIRECTOR NAME <i>Dashiel L. Reese - P.O. Box 666 EASTON MD 26601</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>DEC 1 1980</i>			25b. MEDICAL EXAMINER'S SIGNATURE <i>Rickey Melvin</i>										

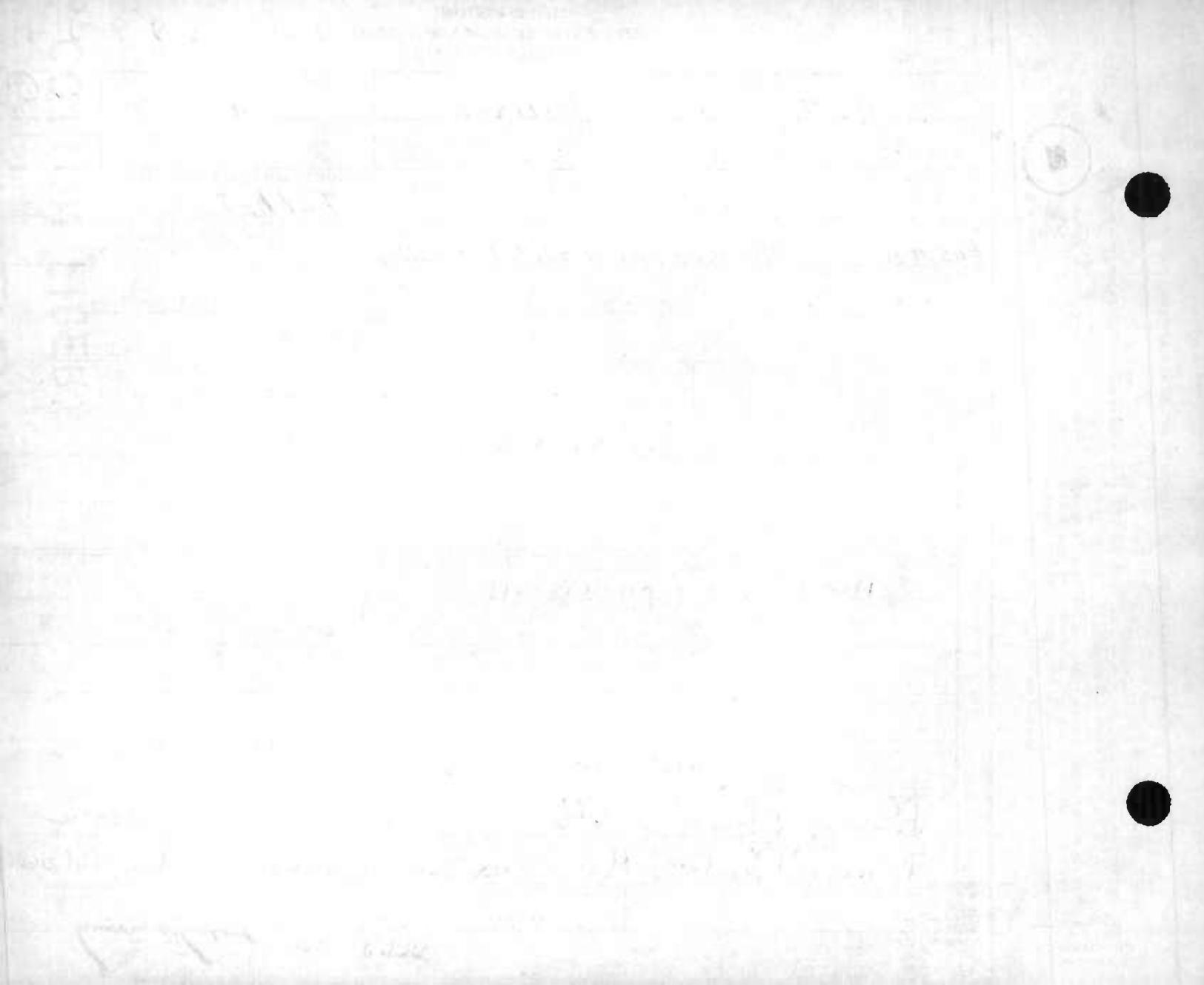


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is necessary to delay the execution of the certificate, the physician should retain it until the funeral director has filed it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29104				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Ruth M Guerin						11 29 80						845 A M		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian		Aug. 1 1912		68			MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
New Jersey			U.S.A.				Talbot			Easton				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
13a. STATE N.J.			13b. COUNTY Essex		13c. CITY OR TOWN Orange		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 418 Central Avenue				
14. FATHER'S NAME John			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME Mary			16. KIND OF BUSINESS OR INDUSTRY Insurance					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Mrs. Marie Kirby Toms River, N.J.			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>4360</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				ADDRESS 19 Ridgewood Village Toms River, N.J.		LAST Jondreau
DUE TO, OR AS A CONSEQUENCE OF (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Atelectasis / pneumonia</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.										22c. DATE SIGNED 11/30/80				
22b. PHYSICIAN'S NAME (TYPE OR PRINT) P. Gradd Rhodes M.D.			22e. ADDRESS 400 Dutchmans Lane, Easton, Md 21601			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-2-80			23c. NAME OF CEMETERY OR CREMATORIAL Jr. Order Cemetery			23d. LOCATION CITY OR TOWN Preston			COUNTRY Caroline		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25. DATE REC'D. BY REGISTRAR DEC 3 1980			SIGNATURE					



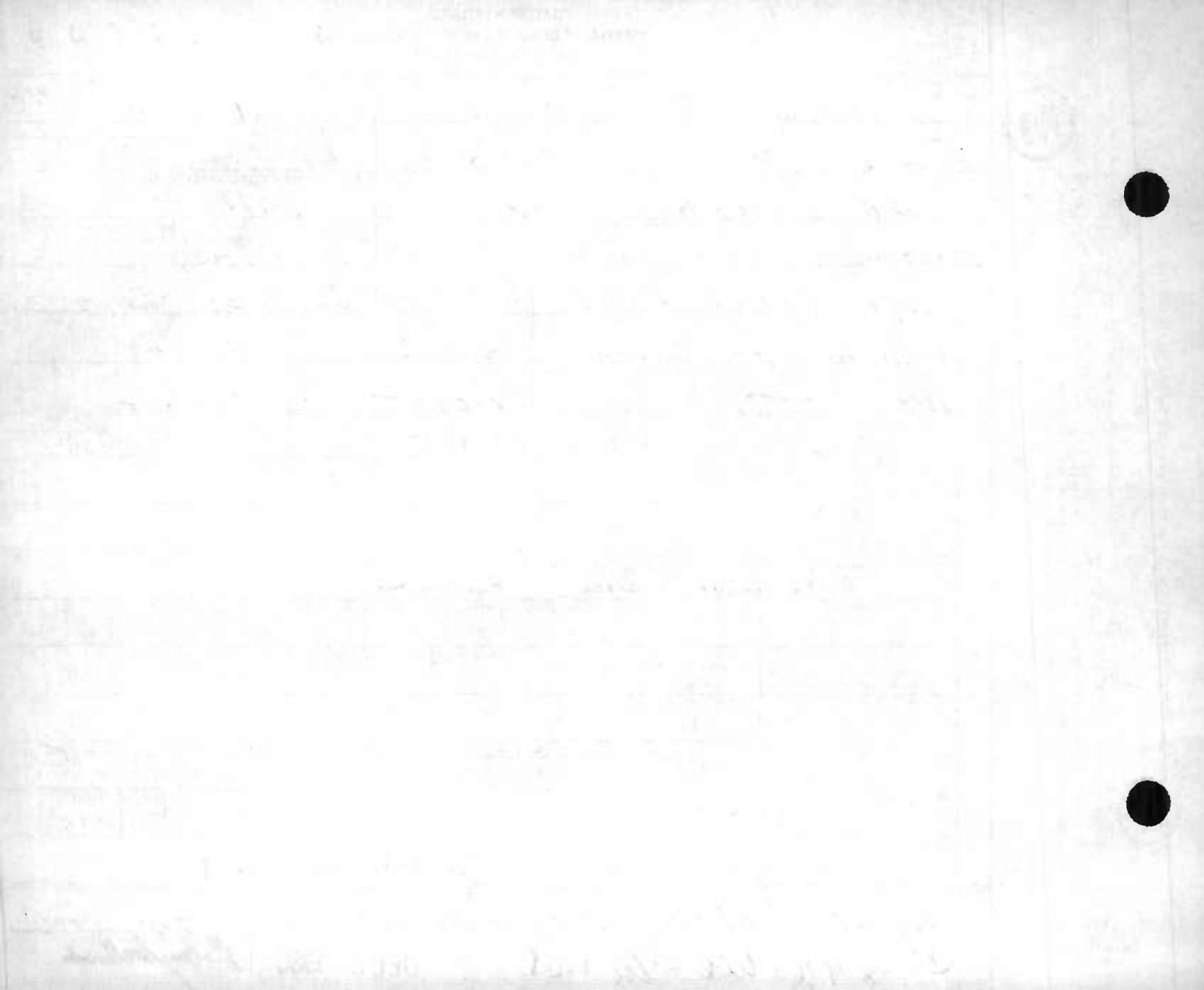
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified and the death certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29105			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Anna E				Harris		14 19 80						9 37A M	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			Negro		Month 3 Day 25 Year 13			67			IF UNDER 24 HRS		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
Md			US					Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Easton			Memorial Hosp@Easton									Domestic	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Md			Talbot		Easton						Kent #1 Box 262		
14. FATHER'S NAME FIRST			MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO			17. INFORMANT ADDRESS		
William			#		Kessie			166. SOCIAL SECURITY NO			Violet		
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			CARDIAC ARREST									2 HOURS	
4275			DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Arteri valve disease			Pneumonia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/16/80 19 to 11/15/80 19, that (I) (we) last saw the deceased alive on 11/15/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE C. R. W. Bain			22c. DEGREE MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/19/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. W. Bain			22e. ADDRESS Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/22/80			23c. NAME OF CEMETERY OR CREMATORIAL unumville ca			23d. LOCATION CITY OR TOWN Easton		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Lynn M. Bell Et al and									25a. DATE REC'D. BY REGISTRAR DEC 3 1980		25b. REGISTRAR'S SIGNATURE Lynn M. Bell		

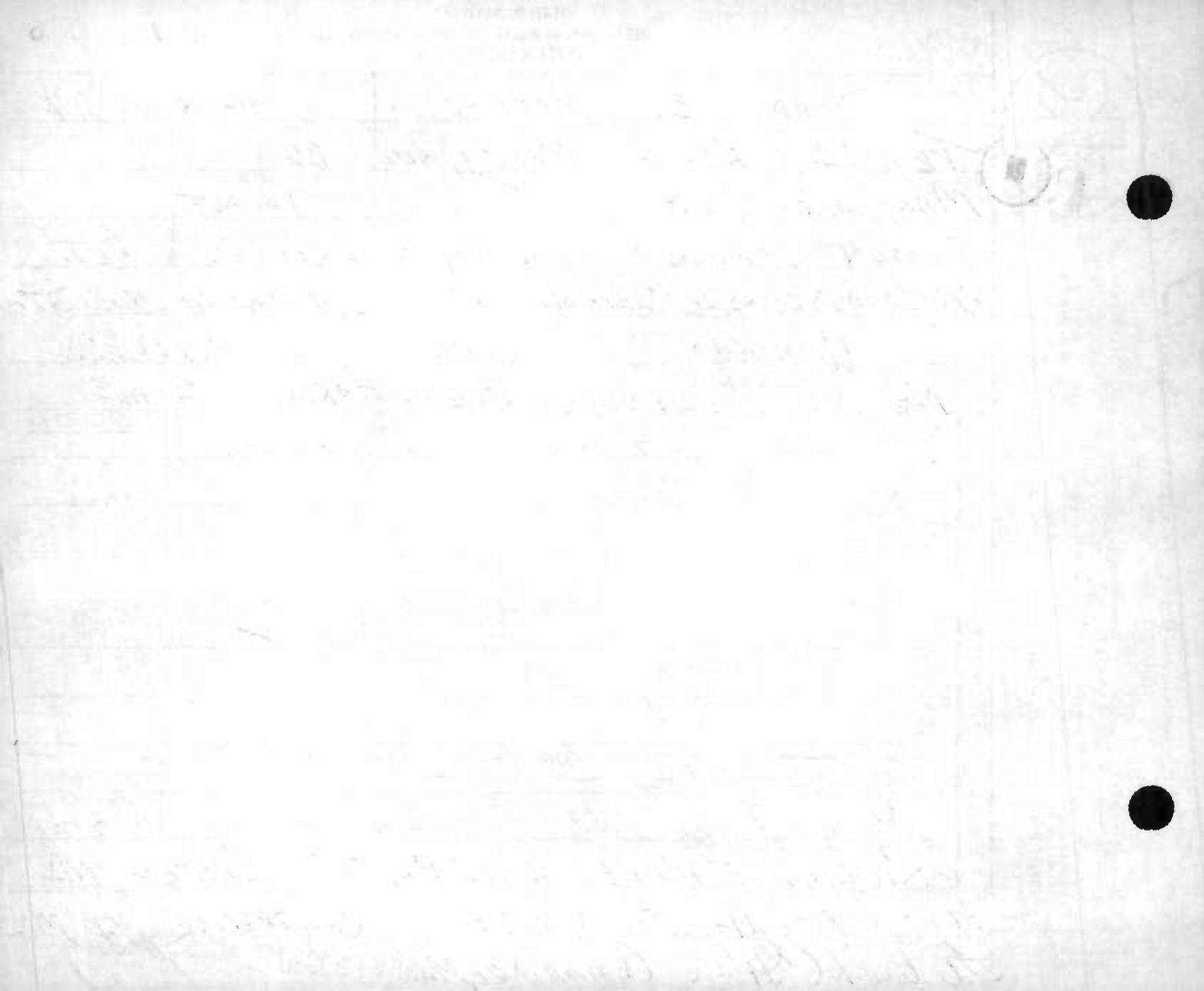


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial or transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	29706						
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
DORA E. HARRIS						11-18-80						9 1/2 M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
FEMALE		BLACK		MAY 24, 1900			80			MONTHS	DAYS	HOURS	MIN.				
YRS.																	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD						
MARYLAND		USA					TALBOT										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
EASTON		EASTON MEMORIAL HOSPITAL			LABORER			RET.									
13. STATE		14. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
MARYLAND		DORCHESTER		CAMBRIDGE					617 WASHINGTON ST.								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST						
Unknown						Daisy					WARFIELD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		214-07-9413			EDGAR HARRIS			SAME									
18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) 5789 q.d. bleed unknown cause.																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterial embolism.</u> -																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>March 1979</u> to <u>Nov 18 1980</u> , that (I) <u>we</u> last saw the deceased alive on <u>11/17 1980</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Richard F. Manegold</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/18/80</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RICHARD F. MANEGOLD</u>		22e. ADDRESS <u>115 Bay St. EASTON, MD.</u>															
23a. BURIAL, CREMATION, REMOVAL (SOCIETY)		23b. DATE <u>11-22-80</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>WAUGH</u>			23d. LOCATION CITY OR TOWN <u>CAMBRIDGE</u>		23e. COUNTY <u>WICOMICKEN</u>		STATE <u>MD</u>						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR <u>NOV 19 1980</u>			25b. REGISTRATION NUMBER <u>100-100000000000000000</u>									
<u>Fredrick C. Flair</u>																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

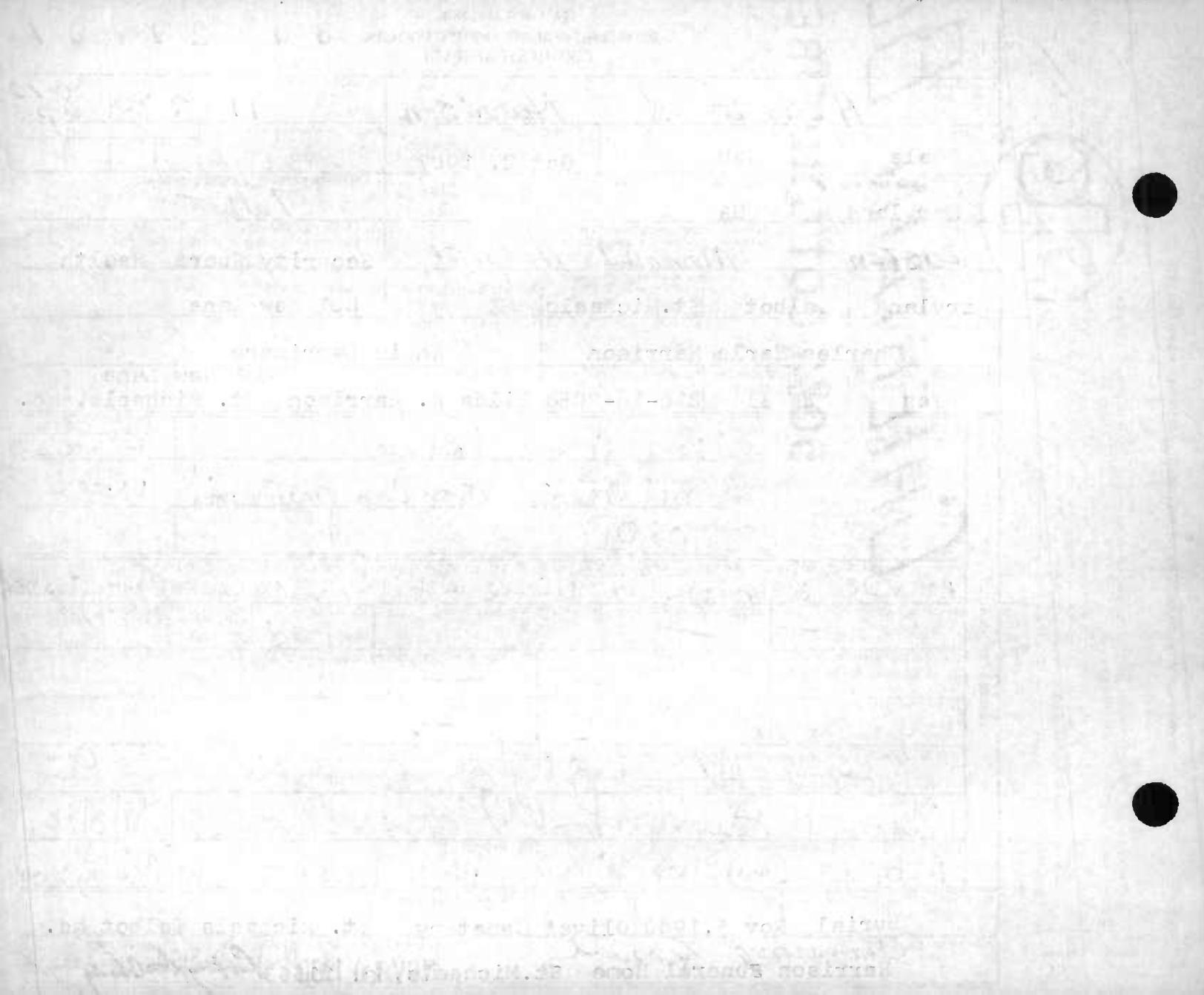
REMAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised and informed.

MEDICAL CERTIFICATION

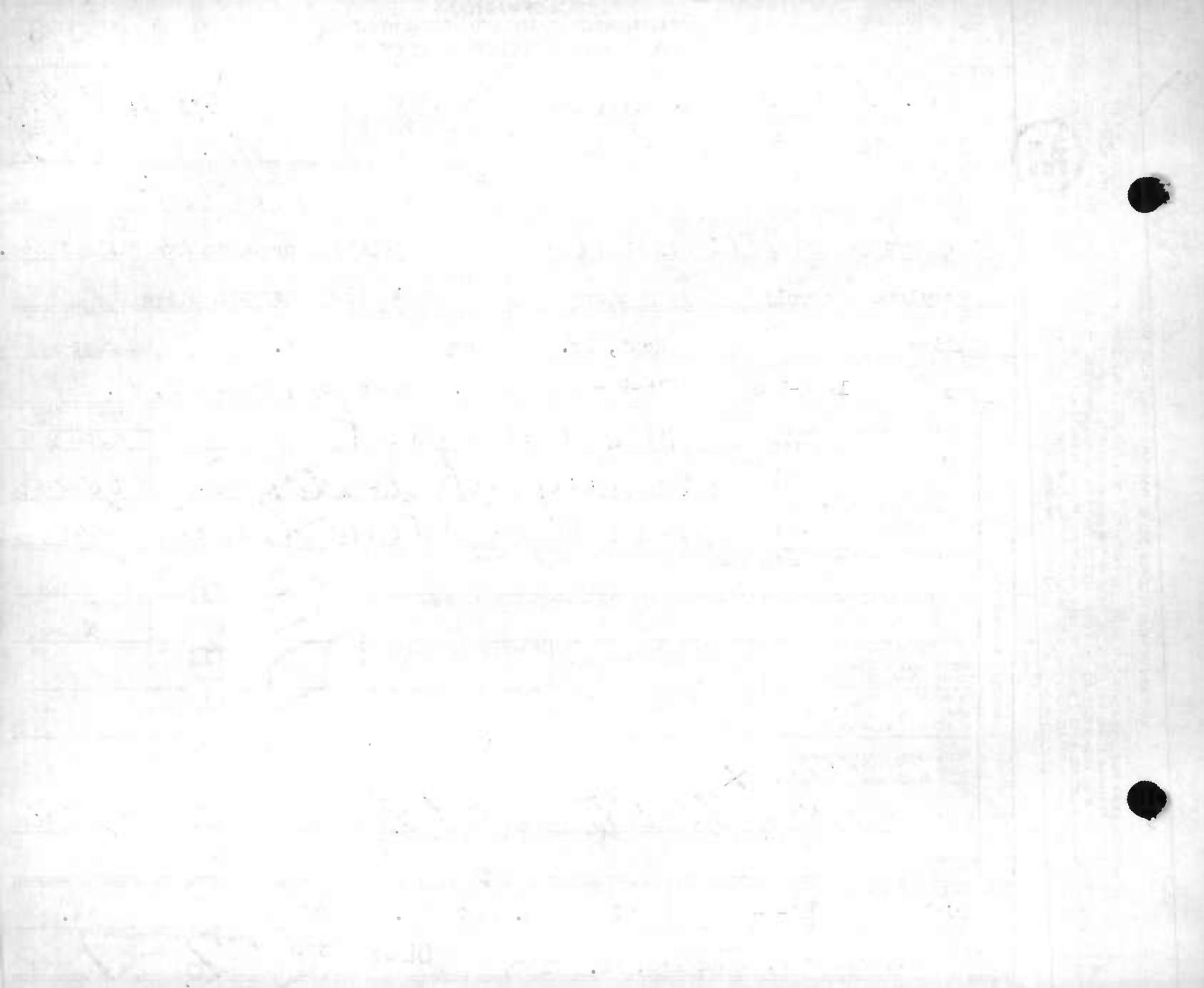
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29707	
										REG. NO.	
1. FOR STATE REGISTRAR			2. DATE OF DEATH							2b. HOUR	
(TYPE OR PRINT)			Herbert R Harrison							11-2-80 8:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		Cau		Oct 2, 1907			73 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Maryland		USA					Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
EASTON		Memorial Hospital		Security Guard		Health					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Talbot		St. Michaels		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		801 New Lane			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		FIRST MIDDLE LAST					
		Charles Earle Harrison		Angie Larrimore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		WW II		216-16-7058		Hilda K. Harrison St. Michaels, Md.		1-2 weeks			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 4960											
DUE TO, OR AS A CONSEQUENCE OF (b) BIL atresia broncho pneumonia 1 week											
DUE TO, OR AS A CONSEQUENCE OF (c) COPD											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. ASCVD curovascular disease + hx(R) middle cerebral artery thrombosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
—		—		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —							
22a. I certify that (I) (this hospital) attended the deceased from 11/29/80 to 11/29/80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. NATURE		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
Albert T Dawkins Jr. M.D.		—		—		11/3/80					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		14 N. AVOR EAST		EASTON MARYLAND 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial Nov 5, 1980		Olivet Cemetery		St. Michaels Talbot, Md.							
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRATION		26. REGISTRATION SIGNATURE							
Harrison & Leonard		NOV 10 1980		B. J. McElroy							
Harrison Funeral Home		St. Michaels		NOV 10 1980							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8029708			
1- FOR STATE REGISTRAR			LAST									2d. DATE KNOWN OF ESTI- MATED			
(TYPE OR PRINT)			FIRST			MIDDLE			MONTH DAY YEAR			2b. HOUR			
William Ronald Hopf									Nov 28 1980 9:30 AM			9:30 AM			
1. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Male		White		Month Day Year			35 yrs.		MONTH DAYS		HOURS MIN		11-28 1980 9:30 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		USA		<input checked="" type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Talbot		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton			Memorial						Field Representative			Rifle Assoc.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland		Carroll		Hampstead			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2304 Susanann Drive					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
William			Mary			215-42-0911			Mrs. Loretta Hopf, Hampstead, Md.			Behrens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 1964-1968			16c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			16d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis									hours years years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. LOCATION			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21e. TITLE (SPECIFY)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>												
EXAMINER'S NAME (TYPE OR PRINT)			M.D.			MEDICAL EXAMINER			DATE SIGNED 11-29-80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-3-80			23c. NAME OF CEMETERY OR CREMATORIUM Moreland Mem. Park Cem.			23d. LOCATION CITY OR TOWN Baltimore			COUNTY STATE Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 8 1980			25b. REGISTRAR'S SIGNATURE						
BP _____															
DHMH - 17 (VR A15 ME (5)) 30M 7/73															



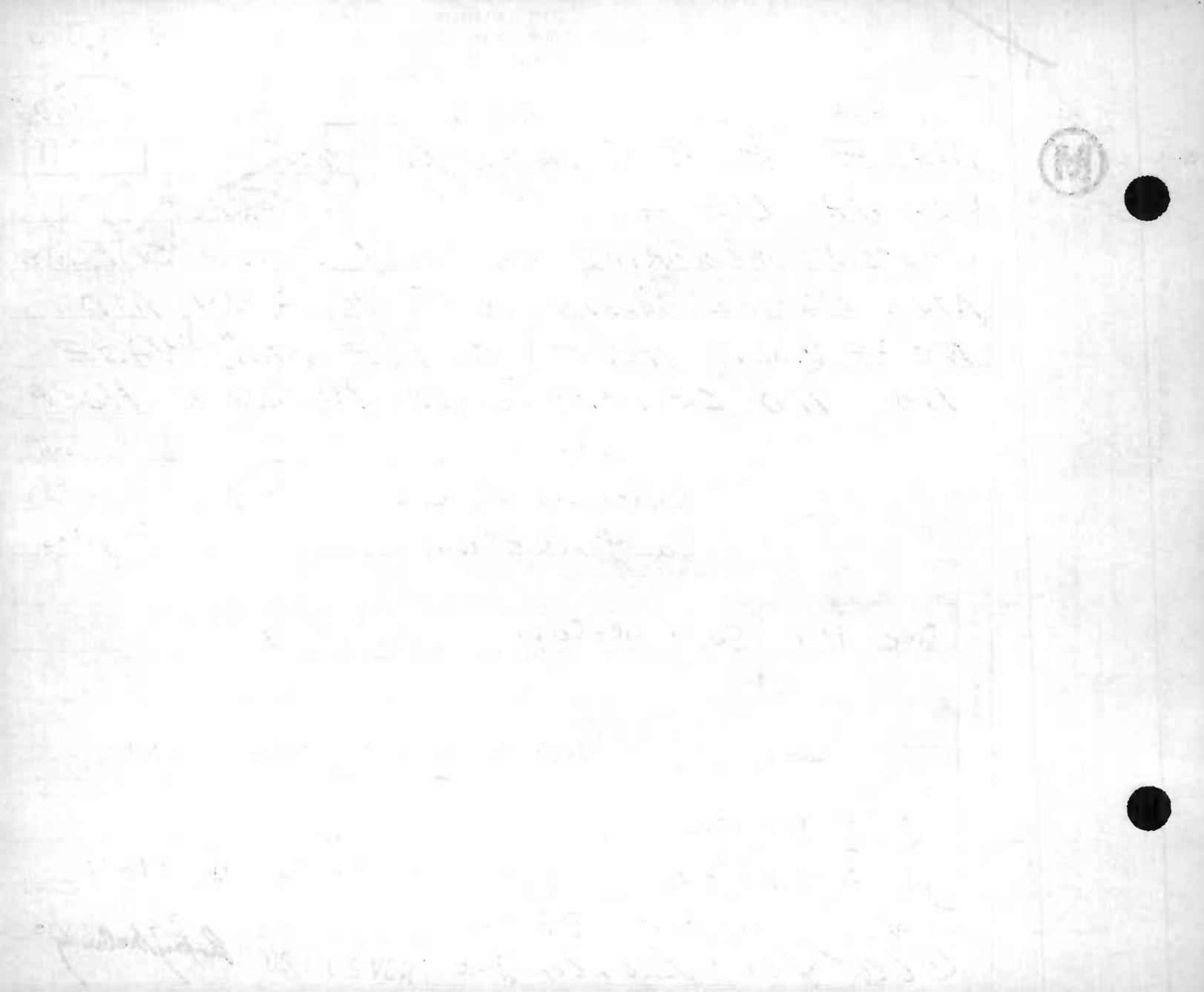
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80	29109					
					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
ASA		L.		HUFF	11	16	80		9:10 A.M.		
3. SEX MALE		4. RACE BLACK	5. DATE OF BIRTH 10/13/1913		6. AGE (IN YEARS LAST BIRTHDAY) 65		IF UNDER 1 YEAR MONTHS 6 DAYS 5		IF UNDER 24 HRS HOURS 9 MIN 10		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT						
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY Soil Cans				
13a. STATE MD.		13b. COUNTY Caroline	13c. CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Ridgeley, MD.				
14. FATHER'S NAME FIRST NOAH		MIDDLE Wm	LAST HUFF	15. MOTHER'S MAIDEN NAME FIRST OLIE		MIDDLE Gynn	LAST WADE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 21516-3677		17. INFORMANT RECORDS - MEMORIAL Hosp						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 month	
18. CAUSE OF DEATH: Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inflammation 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Ca of rectum 18 months 4 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION Dec 1976											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of rectum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1976		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the physician) attended the deceased from 1976 , 19_____, to 11/16 , 19 80 , that (I) (we) last saw the deceased alive on 11/16/80 , 19_____, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J.T.B. Ambler		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21601					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.T.B. Ambler		22e. ADDRESS Box 1025 Easton Md 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-20-80		23c. NAME OF CEMETERY OR CREMATORIAL DENTON		23d. LOCATION CITY OR TOWN DENTON		23e. COUNTY Caroline		23f. STATE md	
24. FUNERAL DIRECTOR NAME Clayell Denton Jr.		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 20 1980		25b. SIGNATURE Rotary Building					



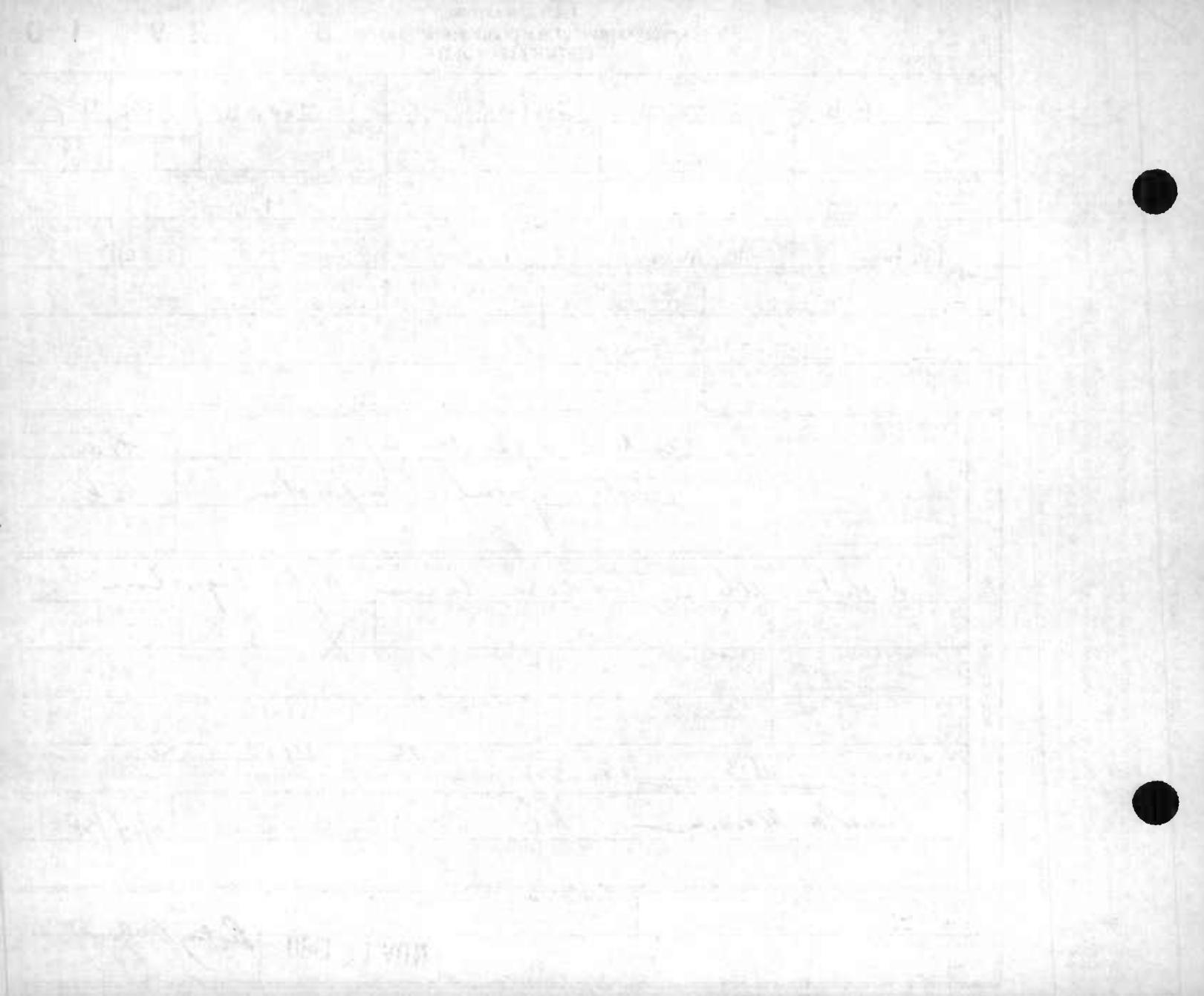
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80	29	10		
					REG. NO.				
1. FOR STATE REGISTRAR	FIRST	MIDDLE	LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)	Robert	Shippen	Diving		November	13	1980		7:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS	7. IF UNDER 24 HRS HOURS MIN.					
Male	Caucasian	June 15 1909	79 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.						
Pennsylvania	U.S.A.								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY						
Easton	the Memorial Hospital	Executive	Bank						
13a. STATE Md.	13b. COUNTY Talbot	13c. CITY OR TOWN Bozman	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Cooper Point Road					
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST				
Robert	Archibald	Irving	Bertha		Shippen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS						
No	188-16-5829	Ruth W. Irving	see item #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral infarct - left</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Hypertension, mellitus, Addison disease, Hypothyroidism</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN						
22a. I certify that (I) (this hospital) attended the deceased from <u>19 72</u> to <u>11/13</u> , 19 <u>80</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> did <u>not</u> view the body after death.									
22b. SIGNATURE <i>Thurston Harrison</i> M.D.									
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>11/14/80</i>								
22e. ADDRESS Dutchman's Lane Easton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11-14-80	23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory Lewes	23d. LOCATION CITY OR TOWN Sussex Del.						
24. FUNERAL DIRECTOR NAME Newnam Funeral Home	ADDRESS Easton, Md.	25. APPROVED BY REGISTRAR NOV 18 1980	REGISTRATION SIGNATURE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						80	29	711					
						REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR				
Victor Edward Jones						11/24/80			12:30 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male		White		8 - 7 - 06		74							
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
DCI		USA				Talbot			Easton				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Memor. at Hospital at Easton						Mechanic			Garage				
13a STATE Maryland			13c COUNTY Caroline		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 331			MD.			
14. FATHER'S NAME John E. Jones					15. MOTHER'S MAIDEN NAME Tinnie Rose								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Mrs. Elizabeth N. Jones, Rt. 2, Box 331,			ADDRESS Federalburg, Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			DUE TO, OR AS A CONSEQUENCE OF (b) ASHD		Acute Myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a COPD, Rheumal Arthritis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/24/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						11/24/80							
22b. SIGNATURE Wm Wood			22c. DEGREE MD ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/24/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WooD			22e. ADDRESS GASTON, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Nov. 26, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery			23d. LOCATION CITY OR TOWN Federalburg, Caroline, Md.			STATE	
24. FUNERAL DIRECTOR NAME Michael A. Lohr			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 4 1980			25b. REGISTRAR'S SIGNATURE Michael A. Lohr				
Flemington - Jenkins Box 43 Federalburg, Md.													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 in
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director:
should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of filing
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

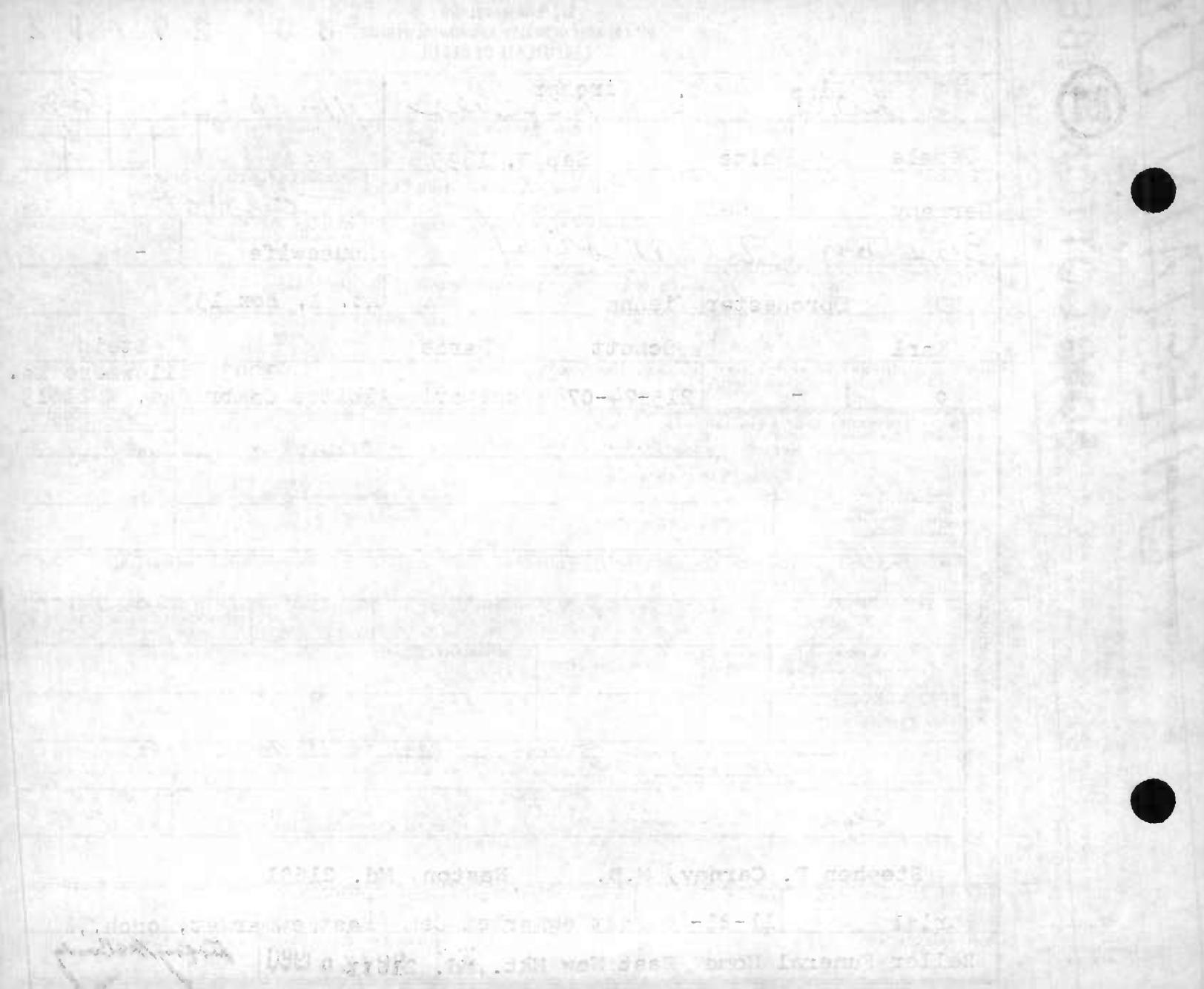
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 29712

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Lina</i>	MIDDLE <i>S. J</i>	LAST <i>Kircher</i>	2a. DATE OF DEATH MONTH <i>Sep</i> DAY <i>3</i> YEAR <i>1895</i>	2b. HOUR <i>6:30 P.M.</i>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH <i>Sep</i> DAY <i>3</i> YEAR <i>1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 85 YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD		13b. COUNTY Dorchester	13c. CITY OR TOWN Vienna	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 133	
14. FATHER'S NAME FIRST Karl		MIDDLE -	LAST Schott	15. MOTHER'S MAIDEN NAME FIRST Marie		MIDDLE -	LAST Stein
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-74-0788		17. INFORMANT ADDRESS Rosemarie Albites Cambridge, MD 21613		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AGNOGENIC MYELOID METAPLASIA 2898 DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) DOUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY STATE
22a. I certify that (I) the hospital attended the deceased from JUNE 1979 to 18 Nov 1980 , that (II) (we) last saw the deceased alive on 18 Nov 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-19-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-21-80	23c. NAME OF CEMETERY OR CREMATORIAL East New Market Cem		23d. LOCATION CITY OR TOWN East New Market, Dorch.	COUNTY MD	STATE
24. FUNERAL DIRECTOR Zeller Funeral Home		ADDRESS East New Mkt., Md.	25a. DATE REC'D. BY REGISTRAR 2 Nov 6 1980		25b. REGISTRAR'S SIGNATURE <i>John J. Murphy</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or antecedent

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	29	13		
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Sarah Rebecca						Lane	11-23-80					11 AM	11 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Cau.		MONTH 9	DAY 18	YEAR 05	75			MONTHS YRS.	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.		U.S.A.					Talbot							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
EASTON				Memorial Hospital						Teacher				
13a. STATE				13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Md.				Talbot	Easton				4 Brookletts Ave.					
14. FATHER'S NAME				MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
James Frank Lane						Margaret Helen Scott								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no				154-24-0106			Margaret Quillen			Immediate				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) Farm cardiac senility										
4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF b) A. S. H. D.										
				DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-7 19-79 to 11-23 19-80, that (I) (we) last saw the deceased alive on 11-17 19-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>John P. Conroy</i>				DEGREE						22c. DATE SIGNED 11-24-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-25-80			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greensboro			23d. LOCATION CITY OR TOWN Greensboro COUNTY Caroline STATE Md.				
24. FUNERAL DIRECTOR <i>John P. Conroy</i>				ADDRESS Greensboro			25a. DATE REC'D. BY REGISTRAR NOV 28 1980			25b. REGISTRAR'S SIGNATURE <i>John P. Conroy</i>				
BP _____														

at

CO-512-6

med

x

Foodstuffs unknown

ova, add 100g. 1% x positive predict 100%

abst. result: seropositive and final result

excretion: mailing sequence: 01-15-14 on

in addition excretion

excretion: 01-15-14

positive

loc. 1 x YR in excretion

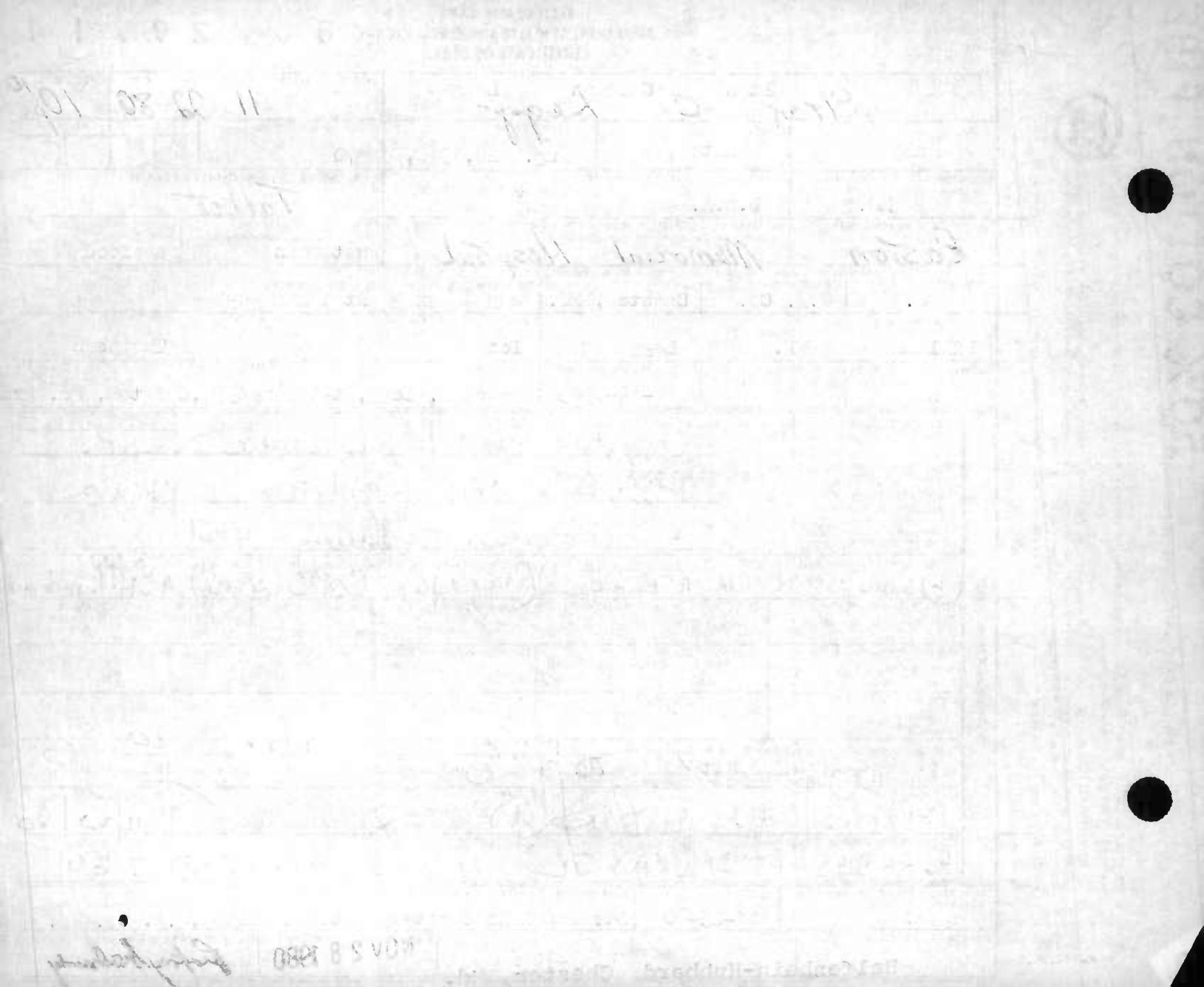
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29714
										REG. NO.
1. FOR STATE REGISTRAR	FIRST Elton	MIDDLE C.	LAST Legg	2a. DATE OF DEATH	MONTH 11	DAY 22	YEAR 80	2b. HOUR 10pm		
1. DECEASED NAME (TYPE OR PRINT)	3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Aug.	DAY 28	YEAR 1910,	6. AGE IN YEARS (LAST BIRTHDAY) 70	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 1 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.							
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman	12b. KIND OF BUSINESS OR INDUSTRY seafood							
13a. STATE Md.	13b. COUNTY Q.A. Co.	13c. CITY OR TOWN Chester, Md.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt#1 Box #493						
14. FATHER'S NAME FIRST William	MIDDLE H.	LAST Legg	15. MOTHER'S MAIDEN NAME Ida							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 218-14-8365	17. INFORMANT Mabel H. Legg, Rt#1 Box#493, Chester, Md.	ADDRESS 21619							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCD = atrial fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>+ cerebrovascular insufficiency = recent</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months. years.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19-16	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11-22 1980								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did (did not) view the body after death.	22b. SIGNATURE PG Rhodes	22c. DATE SIGNED 11/23/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PG Rhodes	22e. ADDRESS AT DAWKINS JL EASTON, MARYLAND 21601	22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. HOSPITAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-25-80	23c. NAME OF CEMETERY OR CREMATORIAL Stevensville Cemetery	23d. LOCATION CITY OR TOWN Stevensville	23e. COUNTY Q.A. Co.	23f. STATE Md.					
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard	ADDRESS 21619 Chester, Md.	25a. DATE REC'D. BY REGISTRAR NOV 28 1980	25b. REGISTRAR'S SIGNATURE Larry H. Brady							

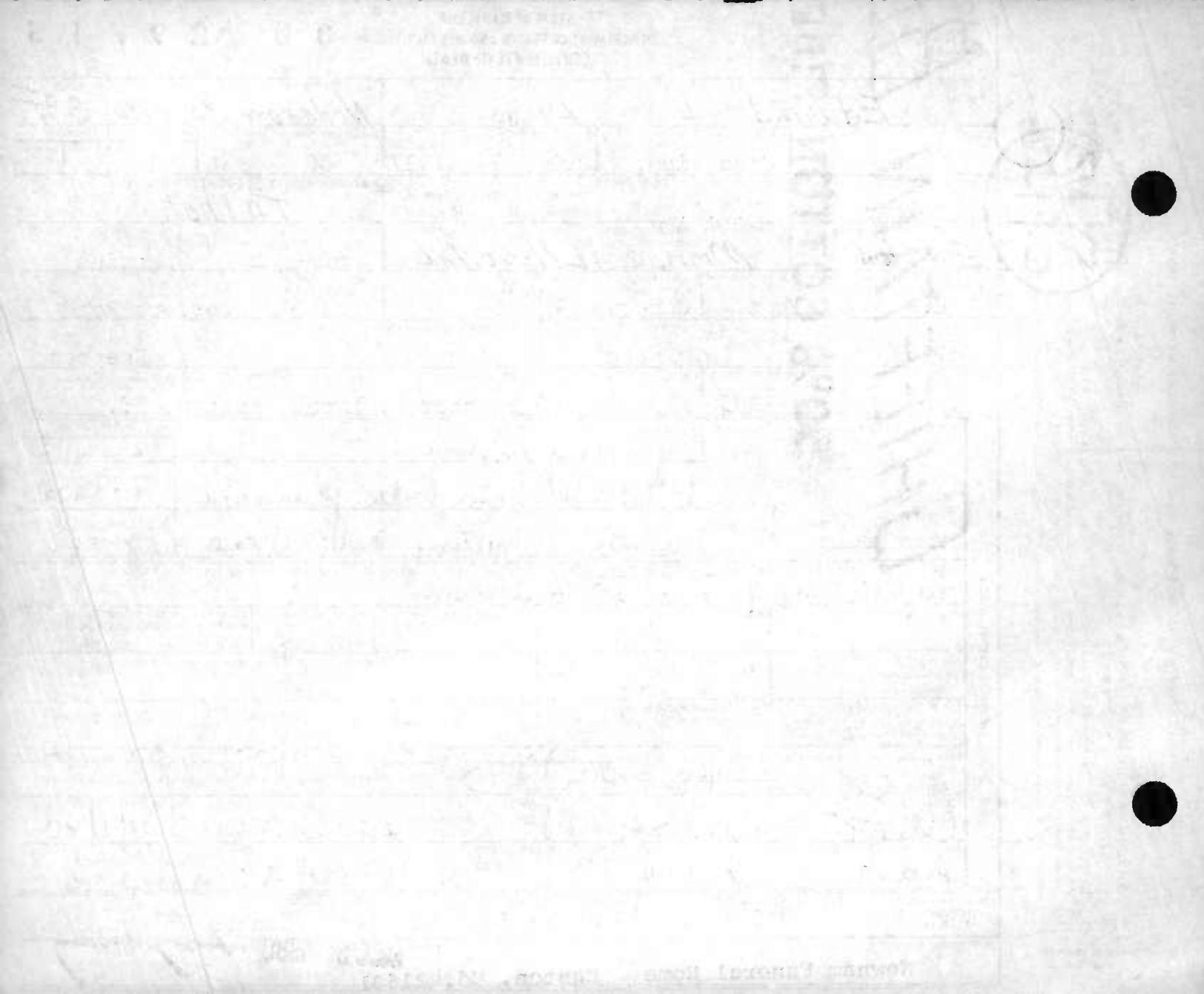


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8029115			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
<i>Edward H. Lyons</i>						<i>November 30 1980</i>			<i>3:55 AM</i>						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male		Caucasian		July 14 1927			53 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Talbot MD.					
Maryland		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<i>Easton</i>		<i>Memorial Hospital</i>										Engineman		Marine	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md.		Talbot		Cordova						Rt. 309		Cordova Road			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Dallas B Lyons		Ada										Spencer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
Yes		1945-1965		215-38-8909			Spencer N. Lyons			306 Winton Ave. Easton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>bilateral lower lobe pneumonia</i>												10 days			
(c) <i>chronic obstructive lung disease</i>												years.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>hepatic insufficiency 20 to cirrhosis</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
—		—													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —											
22a. I certify that (I) (this hospital) attended the deceased from above, (II) (we) did not view the body after death.		10/29 1980		19 80 to 11 30 1980											
22b. SIGNATURE <i>Albert T. Dawkins Jr.</i>		22c. DEGREE													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALBERT T. DAWKINS JR.</i>		22e. ADDRESS <i>14 N. AURORA ST. EASTON MARYLAND</i>													
23a. BURIAL, CREMATION, REMOVAL SPECIES		23b. DATE 12-1-80		23c. NAME OF CEMETERY OR CREMATORIAL Landing Neck Cemetery			23d. LOCATION CITY OR TOWN Trappe Talbot Md.			23e. COUNTY		23f. STATE			
Burial															
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REG. AGENT <i>DEC 3 1980</i>			25b. REG. AGENT'S SIGNATURE <i>Albert T. Dawkins Jr.</i>								
Newnam Funeral Home		Easton, Md. 21601													



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

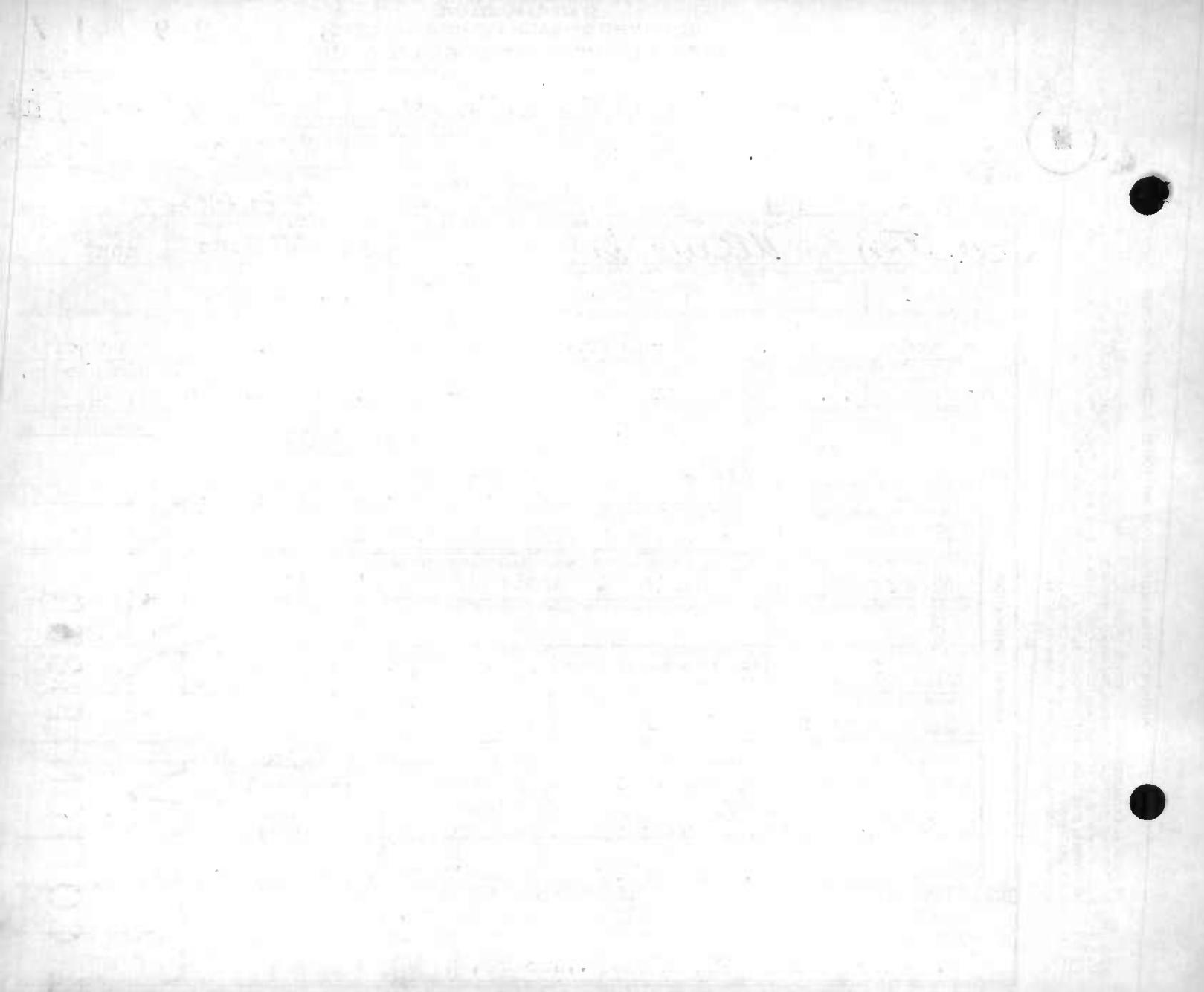
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8029716				
										REG. NO.				
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Elva			McFarland			Nov 9 1885			3:40 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Female			White			April 16, 1885			95			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED X MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
Md.			U.S.A.			XXXXXX XXXXXXXX XXXXXXXX XXXXXXXX								
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Home maker			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Q.A. Co.			13c. CITY OR TOWN Burrisville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS none		
14. FATHER'S NAME John			MIDDLE Edgar			LAST McFarland			15. MOTHER'S MAIDEN NAME Cornelia			LAST Griffin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-4891			17. INFORMANT Alta L. Rhodes, Rt#1 Box#296 Warton, Md.			ADDRESS 21678			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH Enter only one cause per line for 18, 1b, and 1c PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized Arteriosclerosis</u> DOUE TO, OR AS A CONSEQUENCE OF (c) _____ DOUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 9, 1980</u> to <u>Nov 9, 1980</u> that (we) last saw the deceased alive on <u>Nov 9, 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.														
22b. SIGNATURE <u>Richard F. Manegold</u> DEGREE														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED 11/10/80								
Richard F. Manegold, M.D.			115 Bay Street, Easton, MD 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-12-80			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cemetery			23d. LOCATION CITY OR TOWN Centreville, Q. Co. Md.					
24. FUNERAL DIRECTOR NAME Helfenebie Hubbard Funeral Home Chester, Md. 21619			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 14 1980			25b. REGISTRAR'S SIGNATURE <u>Lily J. Kennedy</u>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL Cremation, or Removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 2 9 7 1 7				
1- FOR STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH / DAY / YEAR OF ESTI- MATED <input type="checkbox"/> 11/12/80 7:35 AM									2b. HOUR 2d. HOUR P				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			IF UNDER 1 YR. IF UNDER 24 HRS						2c. DATE PRONOUNCED DEAD 11/12 1980 8:45 AM				
2. SEX 4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS) (LAST BIRTHDAY) YRS.			MONTHS DAYS HOURS MIN			2d. HOUR MONTH DAY YEAR				
Male white			Feb. 17, 1925			55						P				
7. ADDRESS (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. MARRIED <input type="checkbox"/> NEVER MARRIED XX WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.				
USA			USA													
11. CITY OR TOWN OF DEATH Easton			12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION J. McMillan			13a. USUAL OCCUPATION (TYPE OF WORK) parole veteran			13b. KIND OF BUSINESS OR INDUSTRY none							
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Goldsboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 105-C				
14. FATHER'S NAME Haywood			MIDDLE C. LAST McMillan			15. MOTHER'S MAIDEN NAME Martha			16. SOCIAL SECURITY NO. 225-34-0602			17. INFORMANT CHARLES E. McMullan		ADDRESS 3701 Michele Ct. Oakton, VA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. U.S. Navy WW2			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8147			Massive injuries Fractured skull with due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			minutes										
b due to, or as a consequence of bain exposure Compound both bone fracture b due to, or as a consequence of lower left leg Dislocation Right hip c cervical vertebrae Fracture																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Apparently Psychiatric Pt Parole of Perry's point Hospital Perry												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			21a. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Walking Facing traffic in dark clothes			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 P.M. 19			21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Rt 312 Bridgetown			21d. LOCATION approaching vehicle Mayland in highway			21e. CITY OR TOWN COUNTY STATE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>																
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ,			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			22b. DATE SIGNED 11/13/80							
ACTUAL SIGNATURE Harold B. Plummer, M.D.																
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS Preston Maryland 21655			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/17/80			23c. NAME OF CEMETERY OR CREMATORIAL Culpeper National Cem.			23d. LOCATION CITY OR TOWN Culpeper	
24. FUNERAL DIRECTOR NAME J. Berkley Green			ADDRESS 721 Elden St., Herndon, VA			25d. DATE REC'D. BY REGISTRAR NOV 19 1980			25b. REGISTRAR'S SIGNATURE P. Belone							
BP																
DHMH - 17 (VR A15 ME (5)) 30M 7/73																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

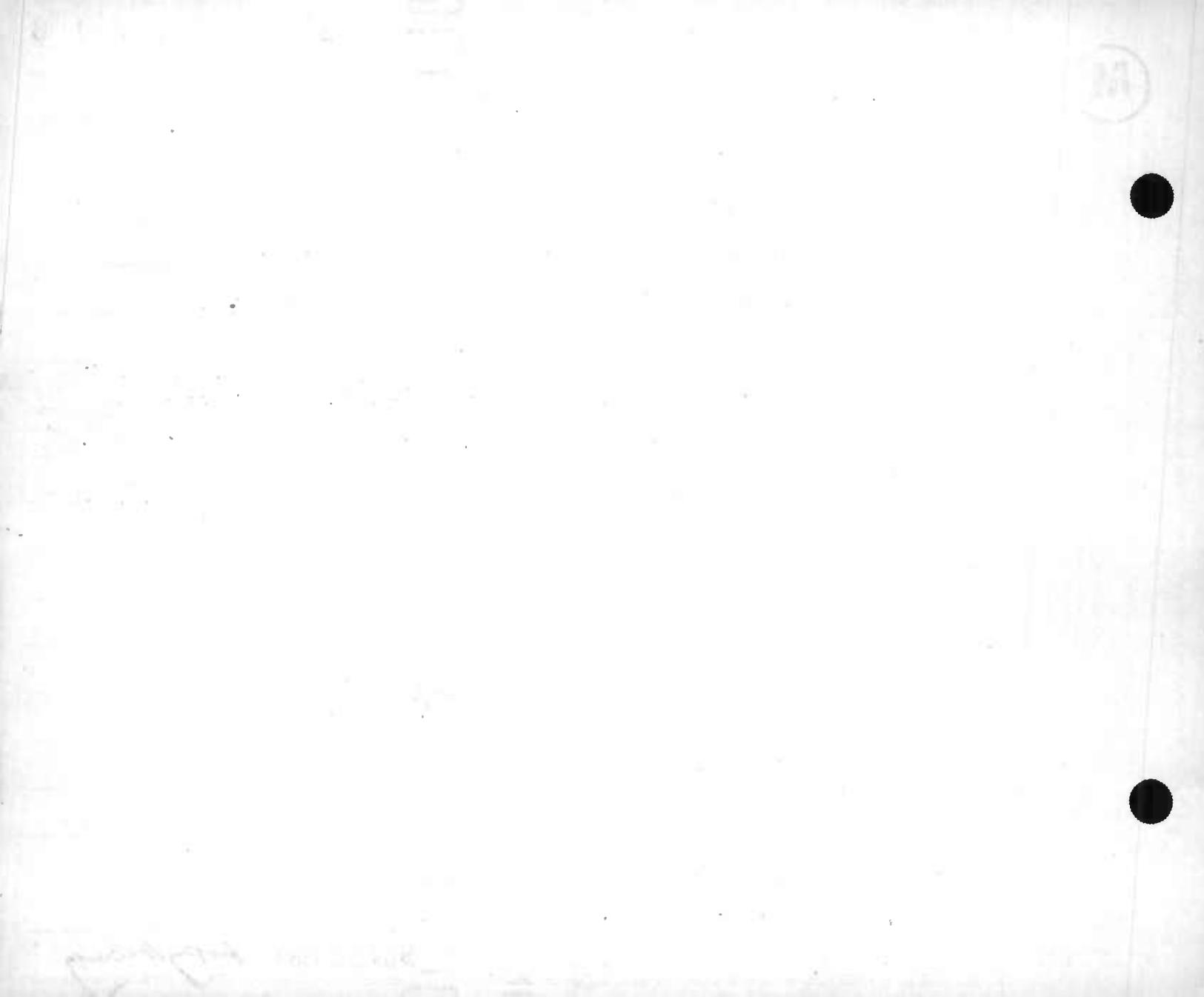
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 29718

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
HAZEL BURNS NORTON						NOVEMBER	20	80		2:00am	
3. SEX	4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	Caucasian	MAY 15 1899			81	MONTHS	YEARS	MONTHS	HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH	
Missouri		U.S.A.								TALBOT MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Oxford		R. D. #1, Box 128			Secretary					Chemical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Del		13b. COUNTY New Castle		13c. CITY OR TOWN Wilmington		13e. STREET ADDRESS 7 Beech Ave.					
14. FATHER'S NAME FIRST unknown			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST unknown			MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
No			221-01-2817		Emily A. Horsey			R. D. #1, Box 128 Oxford, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEPATIC METASTASES.</u>											SEPT 1980
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CARCINOMA COLON</u> (c)											SEPT 1980
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/4/80 to 9/26/80, that (I) (we) last saw the deceased alive on 9/26/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED 11/20/80
22b. SIGNATURE <u>C. R. W. Bain</u>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Callum R. W. Bain, M. D.		14 N. Aurora St. Easton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Cremation		11-20-80		Delmarva Crematory			Lewes		Sussex	Del.	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		Easton, Md.			NOV 25 1980			<u>John Newnam</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 3D1 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIORITY TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8029719				
1- FOR STATE REGISTRAR			2. DATE KNOWN OF ESTI. DEATH MATED									3. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE Powell			LAST Peters			<input type="checkbox"/> MONTH 11 <input type="checkbox"/> DAY 17 <input type="checkbox"/> YEAR 1980				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9c. DATE PRONOUNCED DEAD		10. HOUR <input type="checkbox"/> 10A M <input type="checkbox"/> 10P M		
m		w		12 8 22		57 yrs.						11 - 17 1980				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot							
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital @ Easton			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Engineer Mechanical							
13a. STATE Md.			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.D. #5, Box 400				
14. FATHER'S NAME FIRST Louis			MIDDLE Elwood			LAST Peters			15. MOTHER'S MAIDEN NAME Hattie			16. SOCIAL SECURITY NO.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. WW II & Korea 218-16-7167			17. INFORMANT Martha A. Peters			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4410 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ordinary Campgader</i> Diseasing Anurysm } DUE TO, OR AS A CONSEQUENCE OF (c)			ADDRESS Apt. 1303 1 East Univ. Parkway Balt., Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																
ACTUAL SIGNATURE <i>R. Lane Wroth</i>			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER <i>R. Lane Wroth</i>			DATE SIGNED 11-18-80							
EXAMINER'S NAME (TYPE OR PRINT)			R. Lane Wroth, M. D.			ADDRESS			St. Michaels, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11-18-80			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME			ADDRESS						NOV 20 1980			25b. REGISTRAR'S SIGNATURE <i>Larry Helms</i>				
Newnam Funeral Home			Easton, Md.													



MDA
6-65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

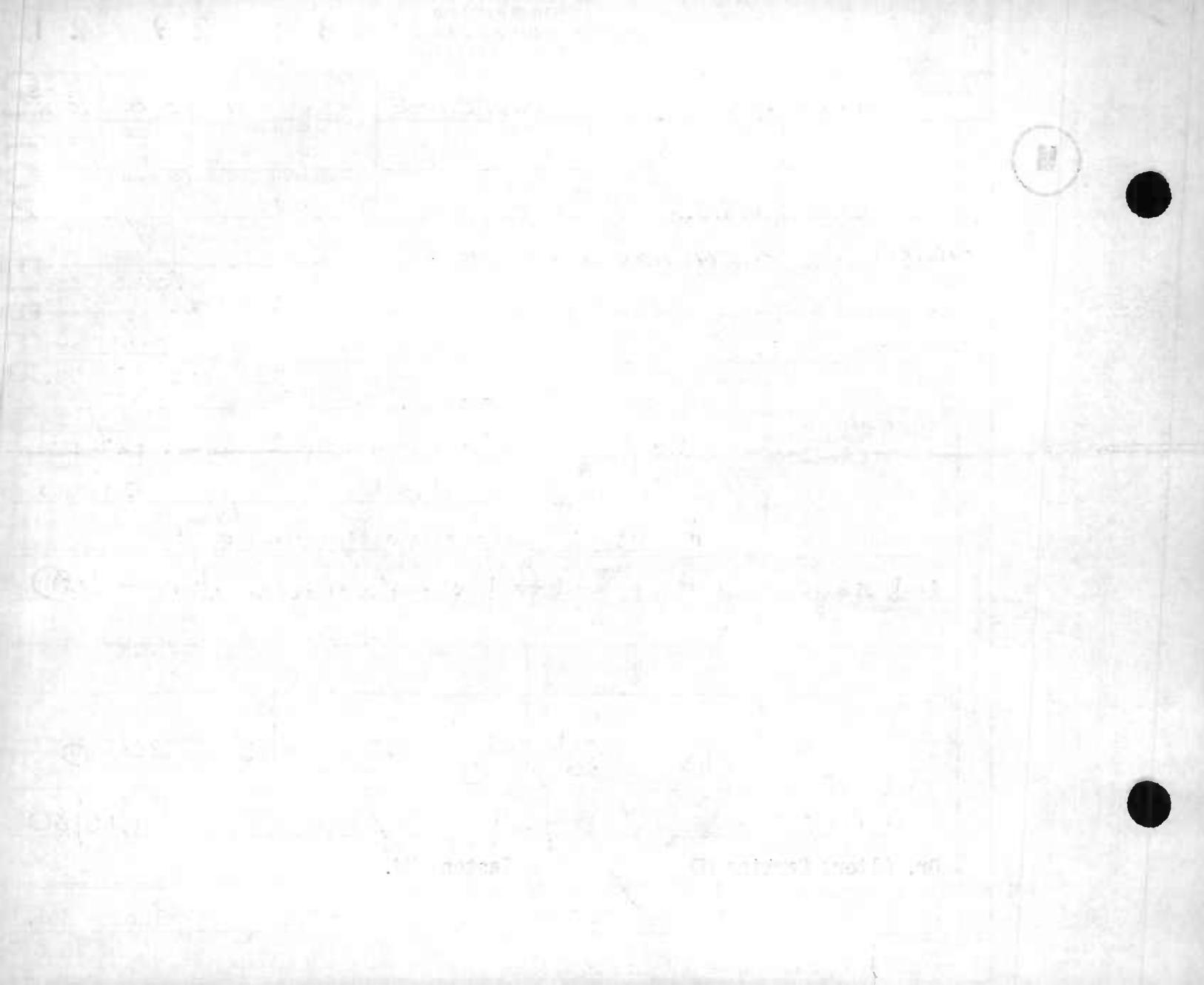
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	29120				
										REG. NO.					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		MONTH DAY YEAR		35 5 AM				
Herman H Roberts									6 15 01						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						
Male			Negro			MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.						
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE md			13b. COUNTY 80			13c. CITY OR TOWN Cessnaville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Raubell Box 225			
14. FATHER'S NAME First: Bob Middle: Roberts			Last:			15. MOTHER'S MAIDEN NAME Mary F. Newmen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 212-12-3568			17. INFORMANT Mother C. Roberts									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) Acute Cardiogenic Shock Probable acute myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 11-6 19-80			21f. LOCATION STREET CITY OR TOWN CITY OR TOWN COUNTY COUNTY STATE STATE			11-4 19-80 to 11-7 19-80						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-6 19-80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Dr. Tomley J. Jr.			DEGREE							22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/28/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL ADDRESS			23b. DATE 11/10/80			23c. NAME OF CEMETERY OR CREMATORIAL Paradise Cem.			23d. LOCATION CITY OR TOWN Towson			COUNTY Towson			
24. FUNERAL DIRECTOR NAME Lynn DeLell Easton m/s			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 20 1980			25b. REGISTRAR'S SIGNATURE Ricky McCreedy						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	0	2	9	7	2	1
1 - FOR STATE REGISTRAR				REG. NO.														
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
MARGARET W.				RUFFRIDGE	11			13	80		10 05 AM							
3. SEX		4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)								
Female		Caucasian		July 13 1901						79 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 1 YEAR MONTHS DAYS			11. IF UNDER 24 HRS. HOURS MIN					
Pennsylvania		U.S.A.					TALBOT						MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		EASTON MEMORIAL HOSP.										Housewife			Boone Creek Road			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Md.		Talbot		Oxford						Crippled Gate								
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST														
Chauncrey		B.	Ware	Bertha									Snedeker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS											
No		214-28-3237		James B. Ware			726 South Elm St.						Hinsdale, Ill.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lactic acidosis + renal failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>4149</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours.			
(b) <i>cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF <i>ASCD & coronary artery disease (severe)</i>															12 hours.			
(c) <i>end stage congestive heart failure + atrial fibrillation - COPD</i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>end stage congestive heart failure + atrial fibrillation - COPD</i>																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <i>August 11 13 1980</i> to <i>4 13 1980</i> , the (1) (we) lost saw the deceased alive on <i>11 13 1980</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did not view the body after death.															22c. DATE SIGNED <i>11/13/80</i>			
22b. SIGNATURE <i>Albert Dawkins MD</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS Easton, Md.													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Albert Dawkins MD																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-16-80			23c. NAME OF CEMETERY OR CREMATORIAL Oxford Cemetery			23d. LOCATION CITY OR TOWN Oxford			COUNTY Talbot			STATE Md.				
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR NOV 19 1980			25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

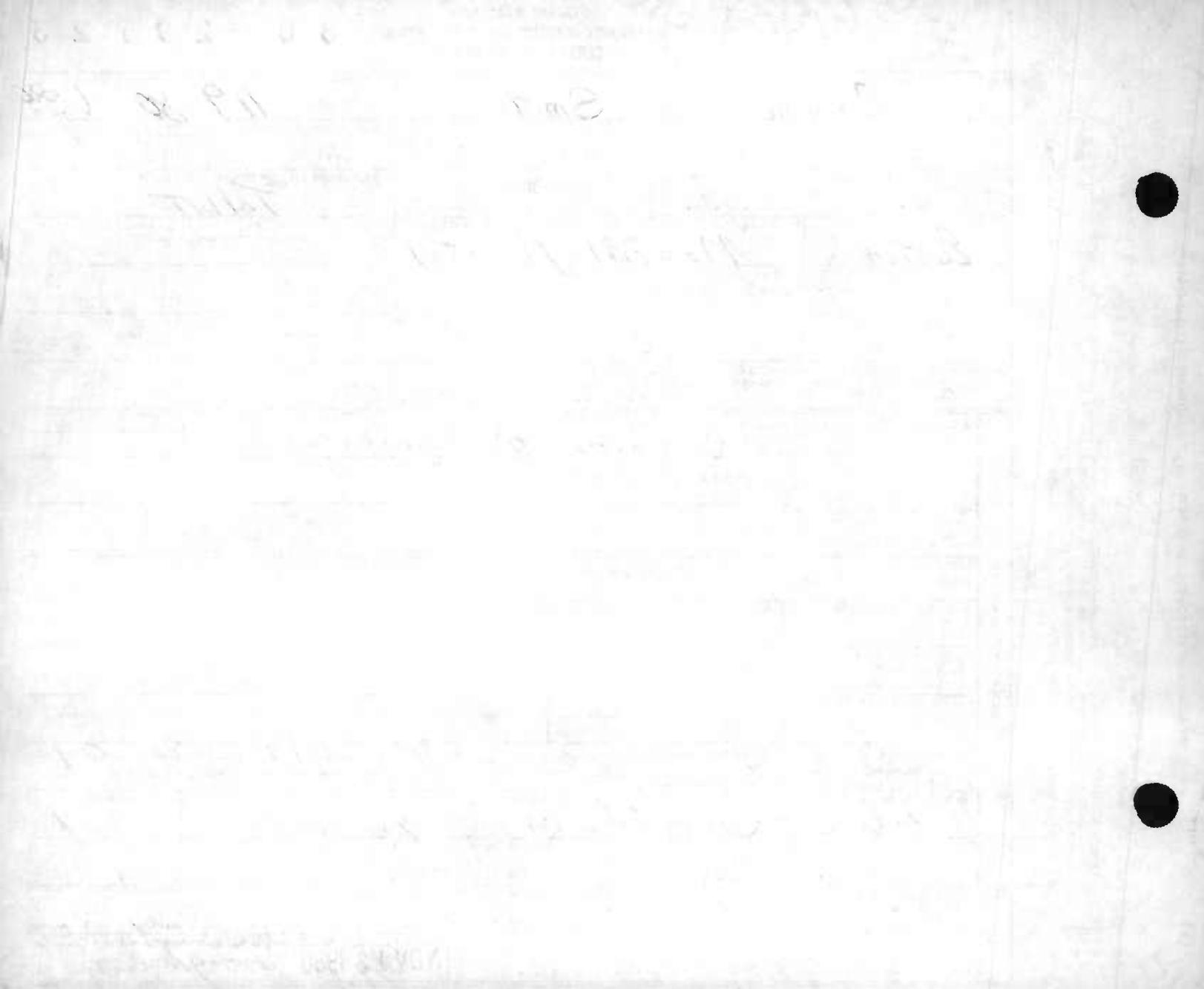
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 9 / 2 2
				REG. NO.
1 - FOR STATE REGISTRAR		MIDDLE	LAST	
1. DECEASED NAME (TYPE OR PRINT)		<i>Helen L. Sharp</i>		2a DATE OF DEATH MONTH DAY YEAR
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR
Female		Negro		January 15, 1908
7a BIRTHPLACE STATE OR FOREIGN COUNTRY		7b CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS
Easton, Maryland		U.S.A.		<input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH
Easton		Alvera		Talbot
13a STATE		13b COUNTY		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Maryland		Caroline		Laborer
14 FATHER'S NAME FIRST		MIDDLE		12b. KIND OF BUSINESS OR INDUSTRY
William Vance Sharp				Factory
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS
No		221-14-5354A		Marjorie Blake, Rt. 1, Box 119, Preston, Maryland 21655
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1820 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		Endometrical Caecum Sarcoma Spreads		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
22a. I certify that (I) (this hospital) attended the deceased from <u>11-4-80</u> , 19 <u>80</u> , to <u>11-11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11-11</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.				
22b. SIGNATURE <i>Edward G. McDonald</i>		DEGREE		22c. DATE SIGNED <u>11-12-80</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS
Edward G. McDonald, M.D.				Easton, Md. 21601
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		Nov. 15, 1980		Mt. Pleasant Cemetery Preston, Caroline, Maryland
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Frampton-Hawkins Box 43 Federalsburg, Md.		21632		NOV 17 1980 <i>Lisette McDonald</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 12 months with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29123		
												REG. NO.		
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			<i>Camille. M</i>			<i>Smith</i>			<i>11-9-80</i>			<i>6:20 AM</i>		
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female			Caucasian			Sept. 13 1906			74 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD		
Conn.			U.S.A.						<i>Talbot</i>			<i>Talbot</i>		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
<i>Elberton</i>			<i>Memorial Hospital</i>			<i>Housewife</i>								
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS		
Md.			Talbot			St. Michael						<i>Rt. 33 Elberton Farm</i>		
14 FATHER'S NAME			MIDDLE			15 MOTHER'S MAIDEN NAME								
Charles			A			Maslin			Mabel			LAST		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			216-46-8150			Chester M. Smith see item #13								
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of pancreas</i>														
1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <i>11-9-80</i> to <i>11-9-80</i> , that (we) last saw the deceased alive on <i>11-9-80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b SIGNATURE <i>William J. Banfield MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <i>11-13-1980</i>					
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS											
William J. Banfield			Dutchman's Lane Easton, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE 11-12-80			23c NAME OF CEMETERY OR CREMATORIAL Old Wye Cemetery			23d LOCATION CITY OR TOWN Wye Mills COUNTY Talbot STATE Md.					
Burial														
24 FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a DATE REC'D. BY REGISTRAR NOV 13 1980			25b REGISTRAR'S SIGNATURE <i>Holiday Belcher</i>					
BP _____														
DHMH-16 25M (VRA 15, 4) 1/79														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 9 1 2 4							
1- FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR							
Joseph S. Steilke					Nov 29, 1980					A 10 AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		WHITE		FEB. 5, 1914		66		MONTHS DAYS		HOURS MIN							
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.									
MARYLAND		U.S.A.				Talbot											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Easton		Memorial Hospital @ Easton				BOILER ENGINEER ST. HOSPIT											
13a. STATE MARYLAND										13b. COUNTY DORCHESTER		13c. CITY OR TOWN WOOLFORD		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME SAMUEL STEILKIE												15. MOTHER'S MAIDEN NAME ESTELLA LARRIMORE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO NO		16c. INFORMANT ADDRESS		17. ADDRESS MARY ELLEN BAINES BOZMAN, MARYLAND											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days -							
55% Mesenteric/sowel infarction																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b)																	
{ DUE TO, OR AS A CONSEQUENCE OF (c)																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ② Pulmonary Emboli ③ Atherosclerotic Heart Disease																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from May - 19 79 to Nov 29, 1980, that (I) (we) lost saw the deceased alive on Nov 29, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not see the body after death.																	
22b. SIGNATURE P. Gregg Rhodes MD.		22c. DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/30/80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Gregg Rhodes MD.		22e. ADDRESS 400 Dutchman's Lane, Easton, Md.						2160									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE DEC. 2, 1980		23c. NAME OF CEMETERY OR CREMATORIAL BOZMAN METH. CEM.		23d. LOCATION CITY/TOWN BOZMAN		COUNTY TALBOT		STATE MARYLAND							
BURIAL																	
24. FUNERAL DIRECTOR NAME Barbara Leonard, St. Michaels Md.										25. REGISTRAR'S SIGNATURE [Signature]							

(M)

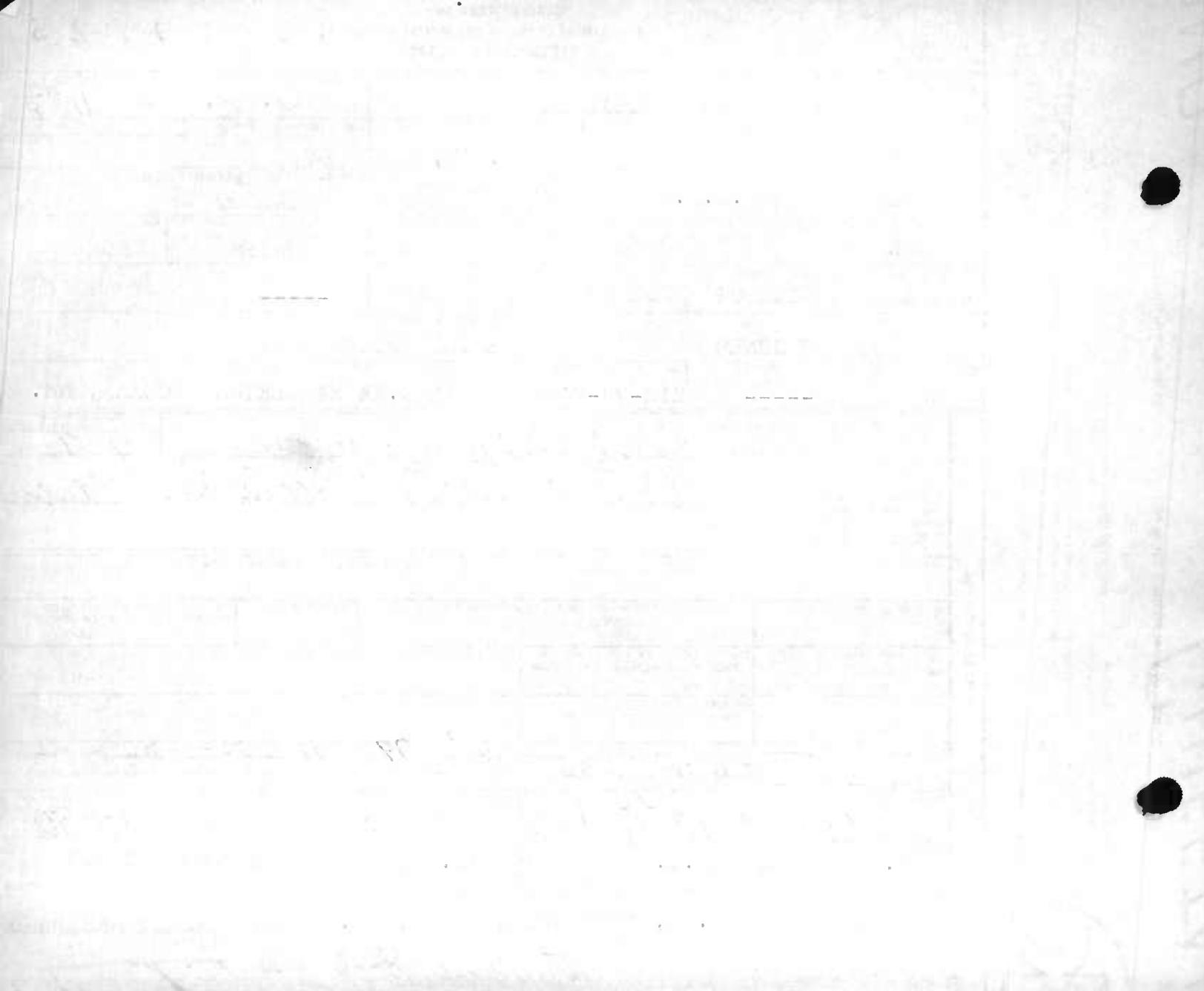


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 9 7 2 5		
												REG. NO.		
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			MARY EVA STEILKIE						NOV. 30, 1980			11:00 P.M.		
3 SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
FEMALE			WHITE			NOV. 11, 1883 97								
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
MARYLAND			U.S.A.						TALBOT					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BOZMAN			BOZMAN			HOUSEWIFE			HOME					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE MARYLAND			13b. COUNTY TALBOT			13c. CITY OR TOWN BOZMAN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
GUSTAVUS JONES			EMILY SUTTON HUNT											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 213-74-9171			17. INFORMANT MAZIE S?MX HAMBLETON			ADDRESS BOZMAN, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a),												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 d.		
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumonia</i> (c) <i>Atherosclerotic vascular disease</i>														
DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 25 Sept 1980 to 30 Nov 1980, that (I) <input type="checkbox"/> lost saw the deceased alive on 30 Nov 1980, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.												22c. DATE SIGNED 12-1-80		
22b. SIGNATURE <i>R. Lane Wroth, MD</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS ST. MICHAELS, MARYLAND 21663								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 3, 1980			23c. NAME OF CEMETERY OR CREMATORIAL BOZMAN METH, CE. BOZMAN TALBOT MARYLAND			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>Harrison E. Leonard</i>			25a. ADDRESS <i>St. Michaels, MD</i>			25b. DATE REC'D. BY REGISTRAR DEC 8 1980			25b. REGISTRAR'S SIGNATURE <i>Harrison E. Leonard</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 9 / 2 6
				REG. NO.
1 - FOR STATE REGISTRAR	FIRST FRANK	MIDDLE K.	LAST TAYLOR	2a DATE OF DEATH MONTH DAY YEAR November 11 1980
1. DECEASED NAME (TYPE OR PRINT)	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR JUNE 21, 1920	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 60	2b HOUR 10 A.M.
3. SEX MALE	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT	10. CITY OR TOWN OF DEATH EASTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CABINETMAKER	12b KIND OF BUSINESS OR INDUSTRY BUILDING	13a STATE MARYLAND	13b COUNTY TALBOT
13c CITY OR TOWN ST. MICHAELS	13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS LINCOLN AVE.	14. FATHER'S NAME FIRST MIDDLE LAST CHARLES A. TAYLOR	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE KENDALL
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES	16b SOCIAL SECURITY NO. 216-01-3880	17. INFORMANT PAULINE E. TAYLOR	18. CAUSE OF DEATH (Enter only one cause per line from Part I or Part II) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (D) 4149 Conditions, if any, which gave rise to immediate cause (D), stating the underlying cause (D). DUE TO DRUG CONSEQUENCE OF DUE TO, DRUG CONSEQUENCE OF	ADDRESS ST. MICHAELS, Md.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH THAT ARE NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET St. Michaels	CITY OR TOWN St. Michaels	COUNTY STATE TALBOT
22a I certify that (I) this hospital attended the deceased from Jan 19 77 to Nov 19 80 , that (I) (we) lost now the deceased alive on Nov 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (not) view the body after death.				
22b SIGNATURE R. Lane Wroth, M.D.				
22c DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d ADDRESS St. Michaels, MD 21663				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE NOV. 14, 1980	23c. NAME OF CEMETERY OR CREMATORIAL OLIVET CEMETERY	23d. LOCATION CITY OR TOWN ST. MICHAELS, MD	23e COUNTY STATE TALBOT
24. FUNERAL DIRECTOR NAME Spruance Leonard, St. Michaels, Md.	ADDRESS	25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE NOV 20 1980.		

10



1001.08714

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 29727													
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Levi									thomas			Nov. 12, 1980						7 10 P.M.							
3 SEX <i>Male</i>			4. RACE <i>African</i>			5. DATE OF BIRTH MONTH 10 DAY 16 YEAR 21			6. AGE (IN YEARS LAST BIRTHDAY) 59			IF UNDER 1 YEAR MONTHS 0			IF UNDER 24 HRS. HOURS 7			YRS. 10							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>			10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>The Memorial Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waterman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>MD.</i>				
13a. STATE <i>Md</i>			13b. COUNTY <i>Talbot</i>			13c. CITY OR TOWN <i>Ridge Bay</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>1 Ridge Bay St</i>													
14. FATHER'S NAME FIRST <i>John E</i>			MIDDLE <i>Thomas Sr.</i>			LAST			15. MOTHER'S MAIDEN NAME FIRST <i>Henry</i>			MIDDLE <i>Fleming</i>			LAST <i>Bethia Thomas</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>WVA 218-16-8769</i>			17. INFORMANT <i>Relative</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>renal cell carcinoma</i> 1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			ADDRESS <i>3 yrs</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
DOUE TO, OR AS A CONSEQUENCE OF																									
DOUE TO, OR AS A CONSEQUENCE OF																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>1 Ridge Bay St</i>			CITY OR TOWN <i>Easton</i>			COUNTY <i>Talbot</i>			STATE <i>Md.</i>										
22a. I certify that (I) (the hospital) attended the deceased from 2-6, 1980, to 11-12, 1980, that (I) (we) last saw the deceased alive on 11-12, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																									
22b. SIGNATURE <i>Stephen P. Carney</i>												DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11-12-80</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen P. Carney, M.D.</i>												22e. ADDRESS <i>Easton, Md. 21601</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>11/15/80</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Richards n.</i>			23d. LOCATION CITY OR TOWN <i>Easton</i>			COUNTY <i>Talbot</i>			STATE <i>Md.</i>										
24. FUNERAL DIRECTOR NAME <i>George A. Marshall Jr. et al.</i>			ADDRESS						25a. DATE REC'D. BY REGISTRAR <i>NOV 20 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Ricky Kennedy</i>													



20-10-1942 modar 20-10-1942 modar

U.S. GOV

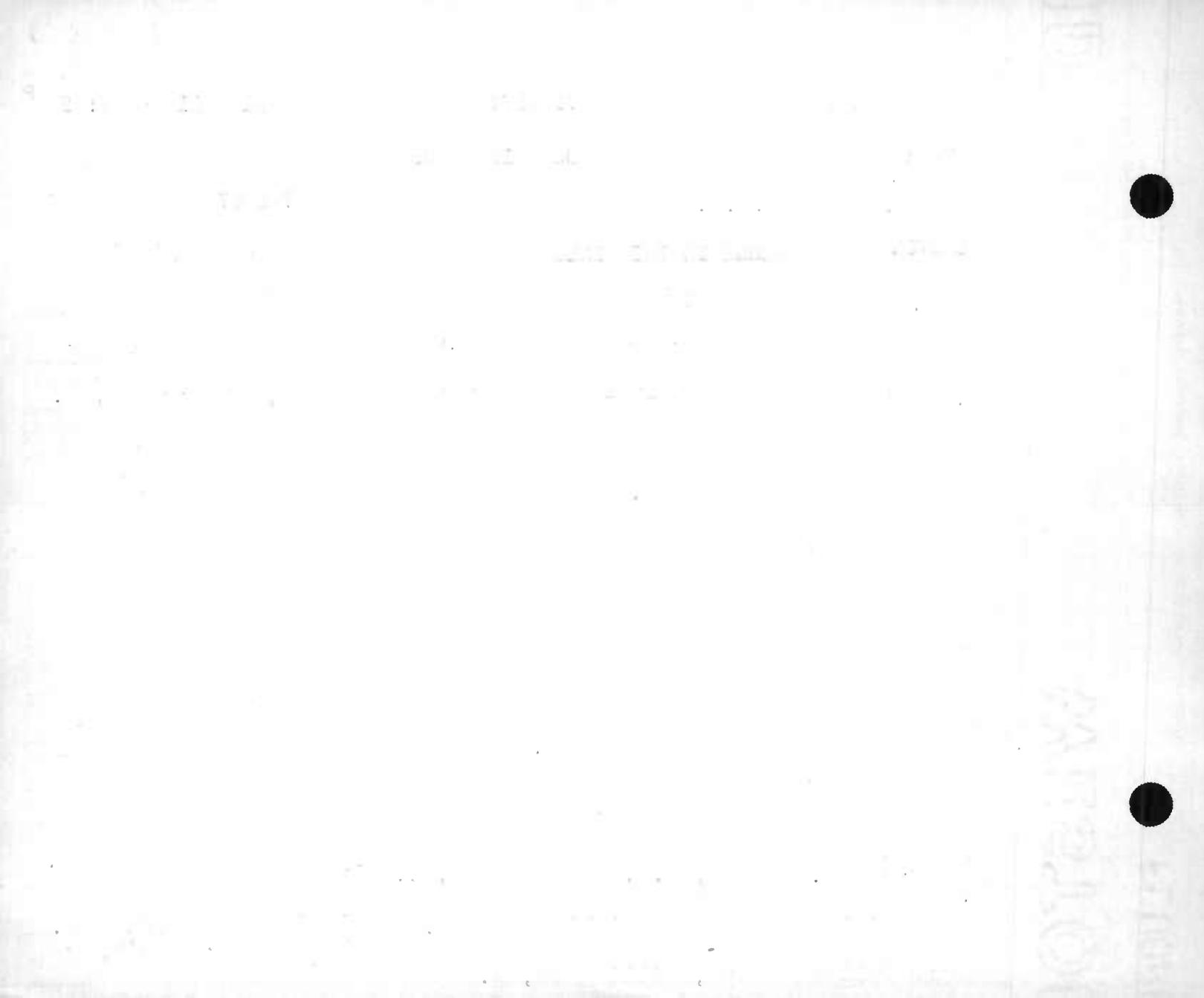
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29728	
												REG. NO.	
1 - STATE REGISTRAR			I - DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			GEORGE			TIBBITT			11 11 80			9:35 P M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
MALE			White			06 10 88			92			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Md.			U.S.A.						TALBOT			YRS.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
EASTON			HOUSE IN THE PINES			Carpenter			Building				
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Kent										
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Samuel Tibbitt			Annie Jackson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No.			218-16-6265			Virginia Fleetwood, Millington, Md.			21651				
18. CAUSE OF DEATH (Enter only one cause per line for 1d), (b), and (c). PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) STROKE												5 DAYS	
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) ASERVED }												MANY YRS.	
} DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (we) attended the deceased from 2-16-80 to 11-11-80, that (I) (we) last saw the deceased alive on 11-6-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE Stephen P. Carney, M.D.												DEGREE	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
Stephen P. Carney, M.D.												22e. ADDRESS	
Easton, Md. 21601												22f. DATE SIGNED	
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE	
Burial			11/14/80			Millington Cem.			Millington			Kent Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Edward Fellows & Son, Millington, Md.			21651			NOV 19 1980			Stephen Carney				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29729	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Viola Moore					R Truxon	November 2, 1980						8:45 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			BLACK			MONTH DAY YEAR			83			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.	
MARYLAND			UNITED STATES						Talbot County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			MD.	
Easton			House in the Pines			(WORKING LIFE)			HOUSEWIFE			NONE	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
14. STATE MARYLAND			14c. COUNTY CAROLINE			13c. CITY OR TOWN DENTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 209 N. 5th STREET	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO NO			16c. INFORMANT RECORDS OF HOUSE IN THE PINES HOME			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			MULTIPLE CEREROVASCULAR										
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b)						ACCIDENTS				
			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
PNEUMONIA													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 1978 to 1980, that (I) (we) lost saw the deceased alive on 10/29/80 1980, and that in (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE C.W. Bain			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/2/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.W. Bain			22e. ADDRESS Easton, Md.										
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 11-5-1980			23c. NAME OF CEMETERY OR CREMATORIUM SANDTOWN CEMT.			23d. LOCATION CITY OR TOWN HILLSBORO CAR. MARYLAND			COUNTY STATE	
24. FUNERAL DIRECTOR NAME CHARLES W. HILL			ADDRESS DENTON, MD.			25a. DATE REC'D. BY REGISTRAR NOV 14 1980			25b. REGISTRAR'S SIGNATURE Patsy McCreedy				

FIGURE A

FIGURE B

16.35

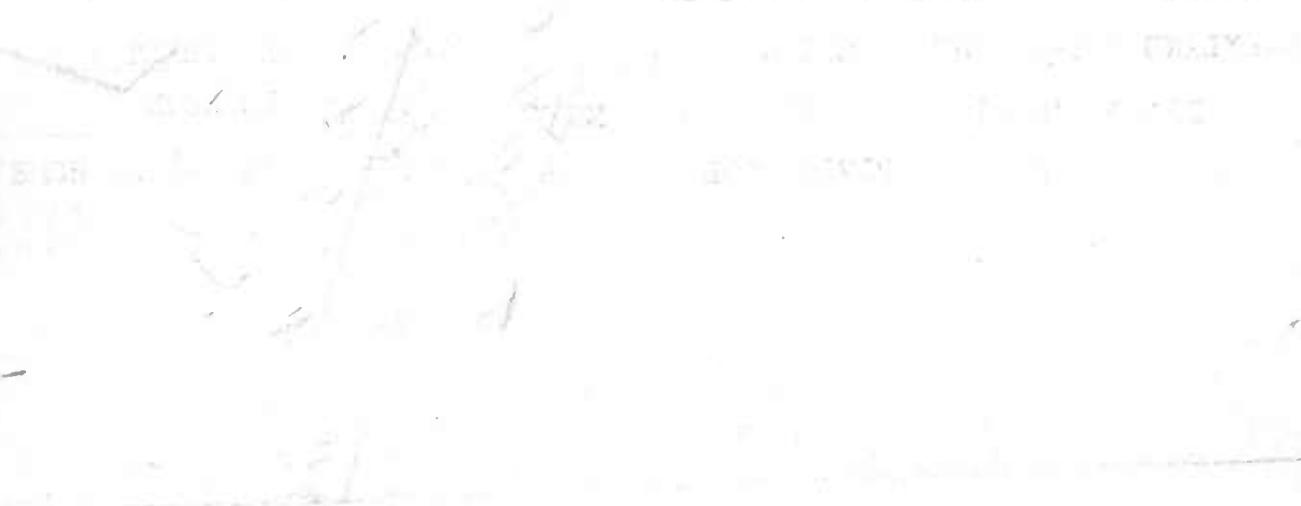
gamma to 2.0

2.0

2.0

gamma to 1.0

not 2.0



2.0

not 2.0

16.35

gamma to 1.0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29130		
										REG. NO.		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		11-8-80		145 PM	
Nicholas Edward Turner												
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.			
M			Negro			8 26 27						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD			
USA			USA									
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE md			13b. COUNTY Talbot			13c. CITY OR TOWN St Michaels			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P.O Box 585
14. FATHER'S NAME First Wilbert			Middle Green			15. MOTHER'S MAIDEN NAME First Harriett			Middle L			Last Jackson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 MO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic cirrhosis, probably primary</i>												
1550 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 3, 1980, to NOV 8, 1980, that (I) (we) last saw the deceased alive on NOV 8, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (did not) view the body after death.												
22b. SIGNATURE <i>Stephen P. Carney</i>			DEGREE						22c. DATE SIGNED 11-9-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL 11/14/80			23b. DATE 11/14/80			23c. NAME OF CEMETERY OR CREMATORIAL Richardson			23d. LOCATION CITY OR TOWN Easton			
24. FUNERAL DIRECTOR Name George & Dr. Bell Estate, md			25a. DATE REC'D. BY REGISTRAR NOV 20 1980						25b. APPROVAL Randy Shadley, md			
BP_____												

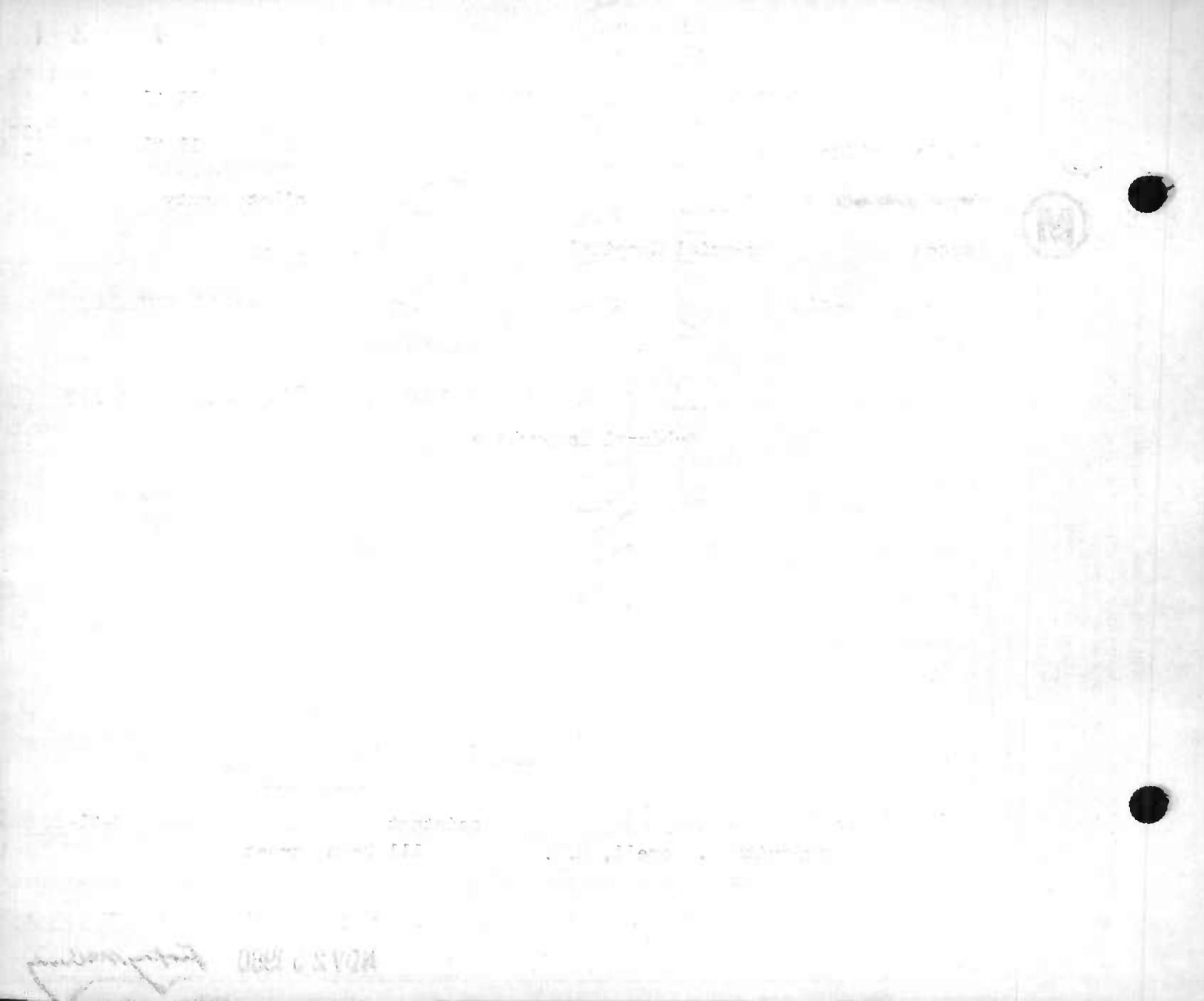
6

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.

TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 4 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE MAILED TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3029731	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN OF ESTI- MATED	2b MONTH DAY YEAR
GENEVIEVE			H.			USILTON						<input type="checkbox"/> 11 21	1980
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. MONTH DAY YEAR	10. HOUR						
female	white	Jan 21 1936	44 yrs	MONTHS DAYS	HOURS MIN.	11 21	1980						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
D. C.		U.S.A.						Talbot County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Memorial Hospital			housewife								
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Cordova		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Skipton-Cordova Road					
14. FATHER'S NAME FIRST Joseph		MIDDLE		LAST Hammet		15. MOTHER'S MAIDEN NAME FIRST unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		579-46-0610		Melvin W. Usilton see item #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: 9889 IMMEDIATE CAUSE (a) Subdural hemorrhage													
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>												DUE TO, OR AS A CONSEQUENCE OF	
{ (b) _____												DUE TO, OR AS A CONSEQUENCE OF	
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE <i>Margarita Korell</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 8-21-80	
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.										ADDRESS 111 Penn Street	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11-25-80		23c. NAME OF CEMETERY OR CREMATORIUM Chesterfield Cem.			23d. LOCATION CITY OR TOWN Centreville			23e. COUNTY Queen Anne	23f. STATE Md.		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR NOV 25 1980			25b. REGISTRAR'S SIGNATURE <i>Sally McElroy</i>						
BP _____													
DHMH-17 (VR A15 ME (5))													
15M 2/80													





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be denoted for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 9 / 3 2				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Blanche			D		Webster	11 - 4 - 80			5 A M	23				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Negro			MONTH DAY YEAR			79	MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Md			US						Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton			Memorial Hospital			Domestic								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			MD.		
Md			Talbot		Easton				69 Talbot village					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
William			Harris			Mary			Cussia					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			—			Mobile			Morfis					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b)														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			11 - 4 - 80 4 - 4 - 80					
22a. I certify that (I) (this hospital) attended the deceased from 11 - 4 - 80 to 19 - 4 - 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (she) (did) (did not) view the body after death.												22b. SIGNATURE DEGREE		
Dr. [Signature]												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
Burial			11/7/80			Carmel			Queen Anne			St. Mary's Co. MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REC'D. BY			25c. REC'D. BY		
Loyd A. Hall			Stn 2nd			NOV 20 1980			Loyd A. Hall			1980		

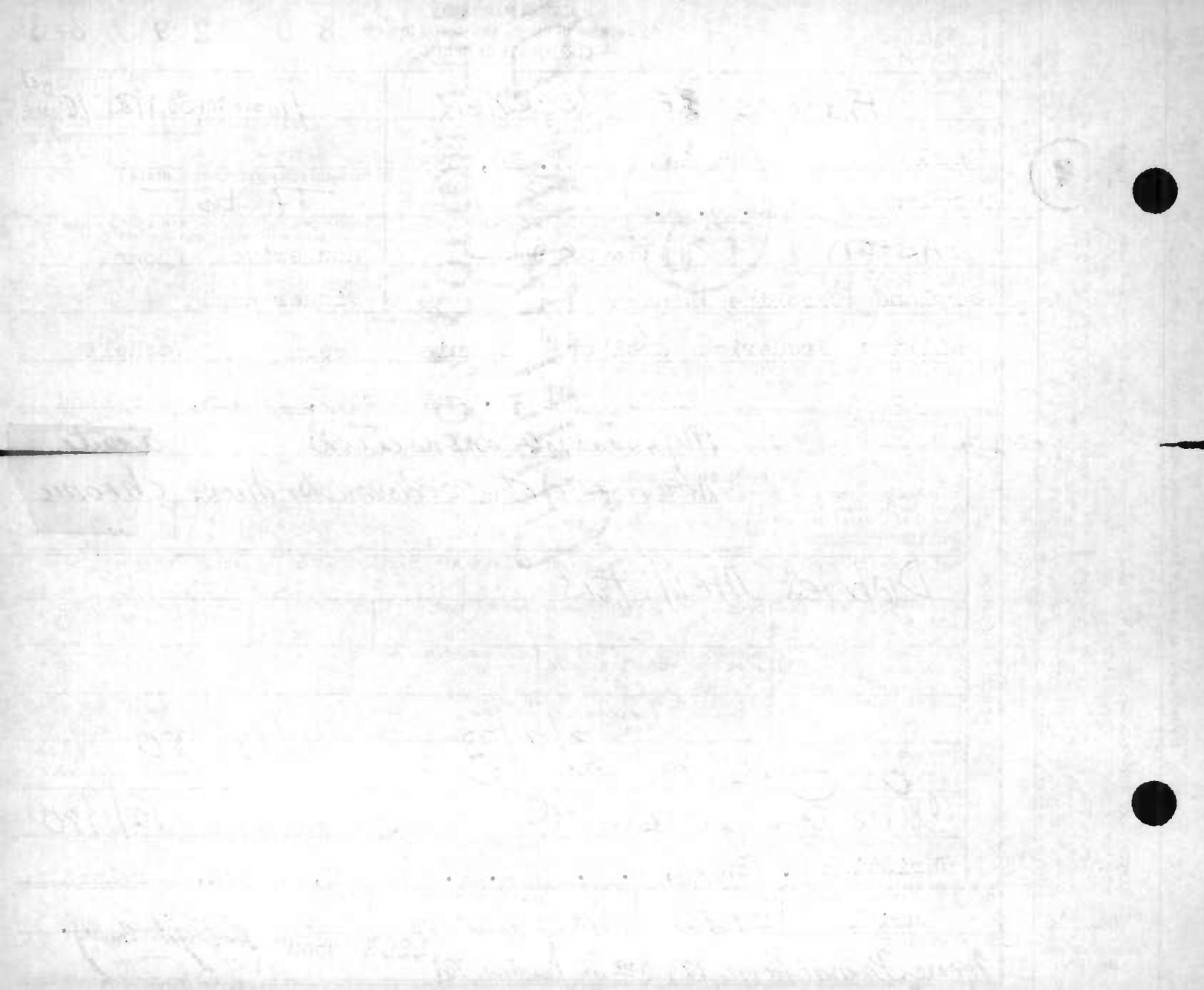


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8029133			
										REG. NO.			
1. FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			Oct. 10, 1899			04				
Frances E. Werner						81 YRS.			10 p.m.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female		Caucasian		Oct. 10, 1899			81			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 7 HRS			
Maryland		U. S. A.					Talbot			HOURS MIN.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
EASTON		Memorial							Housewife			Home	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Fisher Road				
14. FATHER'S NAME FIRST William		MIDDLE Frederick		LAST Kreiger			15. MOTHER'S MAIDEN NAME Fannie		16. SOCIAL SECURITY NO. 213500989		17. INFORMANT Mrs. Pat Hardee, Denton, Maryland		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. ADDRESS		18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute							
No													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction							DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease chronic				
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 319/23 CITY OR TOWN 11/19 80 COUNTY Caroline STATE Md.								
22a.1 certify that (I) (this hospital) attended the deceased from 11/19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not know the exact time of death, we do not know the exact time of death.)													
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/1/80								
Christian E. Jensen, M. D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/3/80		23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery			23d. LOCATION CITY OR TOWN Denton		24. FUNERAL DIRECTOR NAME Moore Funeral Home, 125 S. 2nd St., Denton, Md.				
									25. DATE REC'D. BY REGISTRAR DEC 5 1980				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8029134	
												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			<i>DANIEL</i>					<i>Williamson Jr.</i>	<i>November 2 1980</i>			<i>11 PM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			Black			<i>Dec 21, 1929</i>			50 YRS.			MONTHS DAYS	
7a. BIRTHPLACE (COUNTRY) <i>South Carolina</i>			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>			IF UNDER 1 HOUR	
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Labor</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>construction</i>				
13a. STATE <i>So Carolina</i>			13b. COUNTY <i>Darlington</i>			13c. CITY OR TOWN <i>Darlington</i>			13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
14. FATHER'S NAME FIRST <i>Daniel</i>			MIDDLE <i>Williamson</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Annabell</i>			MIDDLE <i>Wildes</i>	LAST	16. SOCIAL SECURITY NO. <i>248-40-2215</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (YES, GIVE WAR OR DATES) <i>-----</i>			17. INFORMANT <i>Willie James Williamson, Darlington,</i>			ADDRESS <i>Rt #5, Box 47</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>303°</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>303°</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>303°</i>			APPROXIMATE INTERVALS BETWEEN ONSET AND DEATH <i>-----</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Alcoholism</i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alcoholism</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION <i>11-2-80</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Hemorrhagic Encrusted</i>			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>11-2-80</i> , 19 <i>19</i> , to <i>11-2-80</i> , 19 <i>19</i> , that (I) (we) last saw the deceased alive on <i>11-2-80</i> , 19 <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>11-4-80</i>	
22b. SIGNATURE <i>H. M. Walsh, M.D.</i>			22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. M. Walsh, M. D.</i>			22f. ADDRESS <i>Easton, Maryland</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Nov 2, 1980</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Round Oak Cem.</i>			23d. LOCATION CITY OR TOWN <i>Darlington, South Carolina</i>				
24a. FUNERAL DIRECTOR NAME <i>Edward J. Michaels, Jr.</i>			24b. ADDRESS <i>1100 E Leonard, St Michaels, Md</i>			24c. DATE REC'D. BY REGISTRAR <i>NOV 10 1980</i>			24d. REGISTRAR'S SIGNATURE <i>Patricia McNamee</i>				

